

National Sexual Health Strategy



2017- 2030 Agenda

List of Committee Members that worked on developing the National Sexual Health Strategy

Central Administrative Directorate (DAC) of Social Ministries:

Health Directorate (DGS), Healthcare Directorate (DGOS), Directorate-General of Social Cohesion (DGCS), General Secretariat of the Ministry of Social Affairs (SGMAS), Directorate for Social Security (DSS), Interdepartmental Unit For Protecting Women Against Violence And For Combating Trafficking In Human Beings (MIPROF)

Other central administrative directorates:

Interministerial Delegate for Youth, Mainstream Education and Community Life (DJEPVA)

Directorate-General for School Education (DGESCO),

Directorate for Higher Education and Professional Integration (DGESIP)

Directorate-General for Research and Innovation (DGRI)

Academic societies and professional organisations:

College of General Medicine (CMG)

National Teacher's College of General Practitioners (CNGE)

National College of Gynaecologists and Obstetricians (CNGO)

National Commission of Childbirth and Children's Health (CNNSE)

National College of Midwives (CNSF)

College of Presidents of COREVIH (Regional Coordination for the Fight against HIV)

French Federation of Sexology and Sexual Health (FFSSS)

French Society of Dermatology and sexually transmitted pathology (SFD)

Regional Unions of Private Healthcare Professionals (URPS)

Public agencies and institutions:

National Agency for Research on AIDS and Hepatitis Viruses (ANRS)

ANRS - Expert group on the medical treatment of hepatitis

National Public Health Agency (ANSP)

Regional Health Agency of Corsica

Regional Health Agency, Centre

National Health Authority (HAS)

Association of the Departments of France (ADF)

Associations:

Afrique Avenir AIDES

Inter-association Health Collective (CISS)

Doctors of the World (MDM)

French Family Planning Movement (MFPF) SOS Hepatitis Federation

Widespread collaboration

I - List of collaborating parties

Central Administrative Directorates:

Directorate of Research, Study, Evaluation and Statistics (DREES), Ministry of the Interior (DGCL); Ministry of Justice (DAP); Directorate-General of Overseas Territories (DGOM), Interministerial Mission on the Fight against Drugs and Addictions (MILDECA)

National agencies and institutions:

National Health Insurance for Paid Employees (CNAMTS); French National Cancer Institute (INCA), High Council of Public Health (HCSP); Agency for the Safety of Medicines and Health Products (ANSM); College of ARS Director Generals; National Council of AIDS and hepatitis viruses (CNS); National Institute of Youth and Mainstream Education (INJEP); National Institute of Health and Medical Research (INSERM); National Institute for Demographic Studies (INED)

Academic societies and professional associations:

National Association of Midwives and Family Planning (ANSFO); National Association of Abortion and Contraception Centres (ANCIC); Association of Healthcare Professionals Practising in Prisons (APSEP); Federation of Associations for Disabled Adults and Youths (APAJh); Association of French Language Clinical Sexologists; French Medical Register (CNOM); National Register of Midwives (CNOSF); National Register of Pharmacists (CNOSP); National Institute for Demographic Studies (INED); French Society for the Fight against AIDS (SFLS); Inter-university Services for Preventative Medicine and Healthcare Promotion (SIUMPPS); French Language Society for Infectious Pathology (SPILF); National Association of Midwives and Family Planning (ANSFO); National Council of Local Programmes; 3 Free Centres for Information, Screening and Diagnosing of HIV Infections and Hepatitis Viruses (CeGIDD); the 28 COREVIH

National Associations:

National Team for Preventative Healthcare in Business (ENIPSE); HF Prevention; Association of Paralyzed People of France (APF); Hepatitis Virus Collective (CHV); Medical Committee for People in Exile (COMEDE); Paris without AIDS; RESPADD - Network for Addiction Prevention; SAMU social; Sidaction; National LGBTI Federation; Inter-associative Group on Treatment and Therapeutic Research (TrT5); Griselidis, CABIRIA; ARCAT, Le Kiosque/Checkpoint; Regional Centre for Information and Prevention of AIDS, Île-de-France (CRIPS IDF); IKAMBERE; Network of Afro-Caribbean Associations in the Fight Against AIDS (RAAC)

Table of contents

Preamble.....	6
Introduction.....	8
PRIORITY I - INVEST IN THE PROMOTION OF SEXUAL HEALTH, IN PARTICULAR AMONG YOUNG PEOPLE, AS PART OF AN OVERALL AND POSITIVE APPROACH.....	13
AIM 1 - EDUCATE YOUNG PEOPLE ON SEXUALITY, SEXUAL HEALTH AND INTERPERSONAL RELATIONSHIPS.....	14
AIM 2 - IMPROVE SEXUAL HEALTH INFORMATION USING NEW COMMUNICATION TOOLS.....	16
AIM 3 - INCREASE SEXUAL HEALTH TRAINING FOR HEALTHCARE, MEDICO-SOCIAL, EDUCATIONAL, LEGAL AND MEDIA PROFESSIONALS WORKING IN THE FIELD OF SEXUAL HEALTH AND SEXUALITY EDUCATION.....	18
AIM 4 - REINFORCE PARENTS' SKILLS.....	19
PRIORITY II - IMPROVE THE HEALTHCARE PATHWAY IN TERMS OF STIs INCLUDING HIV AND HEPATITIS VIRUSES: PREVENTION, SCREENING, AND TREATMENT.....	20
AIM 1 - REINFORCE AND DIVERSIFY STI AND HIV PREVENTION.....	22
AIM 2 - INCREASE STI VACCINATION COVERAGE FOR VACCINE PREVENTION.....	23
AIM 3 - IMPROVE SCREENING OF SEXUALLY TRANSMITTED INFECTIONS AS PART OF AN OVERALL APPROACH TO SEXUAL HEALTH.....	24
AIM 4 - IMPROVE MEDICAL CARE FOR STIs AND HIV.....	25
AIM 5 - IMPROVE MEDICO-SOCIAL AND SOCIAL SUPPORT, PROMOTE ACCESS TO RIGHTS TO FIGHT AGAINST DISCRIMINATION EXPERIENCED BY PEOPLE LIVING WITH HIV AND VULNERABLE POPULATIONS.....	26
PRIORITY III - IMPROVE REPRODUCTIVE HEALTH.....	28
AIM 1 - GUARANTEE MEN AND WOMEN ACCESS TO THEIR CHOSEN METHODS OF CONTRACEPTION.....	30
AIM 1.1 - Expand information on contraception methods.....	30
AIM 1.2 - Improve access to contraception, in particular in terms of the conventional range.....	30
AIM 1.3 - Mobilise all healthcare professionals and mobilise new stakeholders.....	31
AIM 1.4 - Develop knowledge.....	31
AIM 2 - REDUCE UNPLANNED AND UNWANTED PREGNANCIES.....	31
AIM 3 - PREVENT INFERTILITY AMONG MEN AND WOMEN ACCORDING TO BEHAVIOURAL DETERMINANTS.....	32
PRIORITY IV - MEET THE SPECIFIC NEEDS OF THE MOST VULNERABLE POPULATIONS.....	33
AIM 1 - INTENSIFY PREVENTION, SCREENING, ACCESS TO RIGHTS AND CARE FOR THE POPULATIONS THE MOST EXPOSED TO HIV, HBV, HCV AND STIs.....	34
AIM 1.1 - Aimed at men who have sex with men (MSM).....	35
AIM 1.2 - Aimed at trans people.....	37
AIM 1.3 - Aimed at Populations from Highly Endemic Regions / migrants.....	38
AIM 1.4 - Aimed at other populations exposed to HIV and STIs, hepatitis viruses, violence and unplanned pregnancy - people involved in prostitution, criminal offenders and drug users.....	40
AIM 2 - TAKE INTO ACCOUNT THE SEXUALITY OF PEOPLE WITH DISABILITIES AND ELDERLY PEOPLE.....	42
AIM 3 - TAKE INTO ACCOUNT THE SEXUALITY OF PEOPLE WITH CHRONIC DISEASES.....	43

PRIORITY V - PROMOTE SEXUAL HEALTH RESEARCH, KNOWLEDGE AND INNOVATION	44
AIM 1 - STRENGTHEN HIV MONITORING BY SETTING UP SEXUAL HEALTH INDICATORS	45
AIM 2 - PROMOTE SEXUAL HEALTH INTERVENTION RESEARCH AND INNOVATION.....	46
AIM 3 - DEVELOP KNOWLEDGE OF PSYCHO-SOCIAL SCIENCES.....	46
AIM 4 - PURSUE CLINICAL RESEARCH IN THE FIELD OF SEXUAL HEALTH.....	47
AIM 5 - MAINTAIN A HIGH LEVEL OF RESEARCH INTO HIV/AIDS AND STIs.....	47
PRIORITY VI - TAKE INTO ACCOUNT THE SPECIFIC CHARACTERISTICS OF THE OVERSEAS TERRITORIES TO IMPLEMENT THE SEXUAL HEALTH STRATEGY AS A WHOLE.....	48
MANAGEMENT OF THE NATIONAL SEXUAL HEALTH STRATEGY	50
Summary table of targets.....	54
APPENDIX 1: DEFINITIONS	55
APPENDIX 2: KEY FIGURES.....	57
APPENDIX 3: STRUCTURES AND SYSTEMS IN THE FIELD OF SEXUAL HEALTH	60
APPENDIX 4: THE 17 SUSTAINABLE DEVELOPMENT GOALS (SDGs) OF THE UN 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT.....	61
APPENDIX 5: THE NATIONAL SEXUAL HEALTH STRATEGY AND ITS INTERFACES WITH THE OTHER NATIONAL PLANS AND STRATEGIES AND PLANS AND FRAMEWORKS.....	63
BIBLIOGRAPHY.....	64

Preamble

The National Sexual Health Strategy is part of the implementation of the national and Overseas Territories health strategy. It falls within **a comprehensive approach** to improve sexual and reproductive health. It is based on the following core principles: sexuality must be founded on independence, satisfaction, and safety. It takes into account unequal relations between the sexes and sexualities, which affects universal access to sexual health services.

We took the decision to develop this strategy **in coordination with stakeholders on the ground**, which enabled us to identify the major priorities covering all areas:

- **Promotion of health and preventive healthcare** by acting early and forcefully on everything that has an influence on our health;
- **Promotion of human rights and how this is conveyed in legislation**: prohibiting discrimination, fighting for equality between men and women, promoting an approach that is centred on the individual in their environment, and an approach that is ethical;
- **Organising patient-centred care that guarantees patients equal access**;
- Contributing to **health democracy**;
- **Fighting against social and territorial inequality** by focusing on the **decentralisation of public policies**.

It addresses the population as a whole, connecting intervention by the professionals, services and establishments of an area to set up a pathway in which a person is the main driving force of their health.

Furthermore, taking into account the specific needs of certain populations, an **intensified, population-centred approach** is required to ensure the actions adapted to the following groups are implemented: populations that are more exposed to violence and/or to human immunodeficiency virus (HIV), to sexually transmitted infections (STIs), to hepatitis viruses, and/or to discrimination and/or those furthest from general sexual health services.

We must ensure that it is possible for people to choose to conceive children if they wish to and when they want, within a context of satisfying, responsible and safe sexuality.

We want to **end the AIDS epidemic by 2030** and ensure that 95% of all people living with HIV are aware of their HIV status, that 95% of person who know they are HIV positive have access to treatment, and that 95% of people being treated have a suppressed viral load by 2020. **We also aim to eliminate epidemics of sexually transmitted infections as being major public health problems.**

The National Sexual Health Strategy develops **voluntary activities related to information, health education and communication**, with priority being given to the health of young people, as well as **boosting the training and mobilisation of health professionals**, in particular those in primary care.

Lastly, it has been developed in conjunction with other strategies that impact sexual health being implemented by the Ministry of Health, the Ministry of Women's Rights, the Ministry of National Education, the Ministry of Youth Affairs, the Ministry of Foreign Affairs and International Development, and/or other central administrations as well as institutions and associations, following a policy of **collaboration** and a **comprehensive approach to matters of sexual health**.

I would like to thank all of our partners who contributed to the development of this National Sexual Health Strategy, and I am counting on you to be by our side as it is rolled out.

Prof. Benoît Vallet

Director-General for Health

Introduction

According to the World Health Organization (WHO)⁽¹⁾: *“Sexual health is a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled.”* Sexual health is an integral part of health, well-being and quality of life as a whole.

A framework defined in keeping with other steps that structure and influence the scope of sexual health.

The National Sexual Health Strategy covers the following areas:

- access to human rights ⁽²⁾, respecting genders and sexualities
- promotion of sexual health by means of information, education, communication and sexual health training;
- information on sexual dysfunctions and disorders, and how to prevent, screen and treat these;
- prevention through HBV and HPV vaccination, screening and treating STIs, including HIV and hepatitis viruses;
- promotion of reproductive health (prevention of infertility caused by infection, contraception, abortion and prevention of unwanted/unplanned pregnancies);
- the fight against discrimination on the basis of sex, sexual orientation or gender identity;
- prevention of sexual violence.

Maternal and child health and medically-assisted reproduction are not covered by this strategy, and are dealt with by specific national policies. It will be ensured that this strategy will be consistent with and linked to these policies.

Progress, yet still a long way to go

France takes action in the field of sexual health through multiple health plans or programmes which implement steps using theme-based approaches, mainly focussed on the idea of risk, yet do not always present a comprehensive vision.

Significant progress has been made in recent years with regard to legislation and measures promoting sexual health and the fight against human immunodeficiency virus (HIV), hepatitis viruses and other sexually transmitted infections (STIs):

- Introduction of the concept of sexual and reproductive health to the Public Health Code (article 10 of the law of 26 January 2016 on the modernisation of our health system);
- Creation of a health education pathway for all pupils ⁽³⁾. The health education pathway explains what is offered to pupils in terms of health at school, regional and educational institution level, which is closely connected to the region;
- Creation of free centres on 1 January 2016 for obtaining information, for screening and diagnosing infections caused by the human immunodeficiency virus, hepatitis viruses and sexually transmitted infections (CeGIDD), which result from a merger between the Free and Anonymous Screening Centres (CDAG) and Information, Sexually Transmitted Infection Information, Screening and Diagnosis Centres (CIDDIST), the missions of which have been expanded to form a comprehensive approach to sexual health;
- Development of recommendations for the treatment of people infected by the hepatitis B or C virus, published in 2014/2016 ⁽⁴⁾ and the medical treatment of people living with HIV ⁽⁵⁾ ;

- Progress in the prevention of HIV (HIV pre-exposure prophylaxis (PrEP)), diversifying the means for screening HIV, HCV and sexually transmitted infections (rapid diagnostic test (RDT), self-sampling, self-testing, etc.);
- Improvement to abortion services: offering surgical abortion services at health centres and expanding the skills of midwives to include medical abortions, decrease in the time required for consideration to one week (article 82 of the law on the modernisation of our healthcare system), arranging to have 100% of abortions covered by health insurance.
- Ensuring access to contraception for all young women who are underage;
- Elimination of discrimination based on sexual orientation with regard to blood donations (article 30 of the law on the modernisation of our healthcare system).
- However, following the evaluation of the 5th plan for the fight against HIV/AIDS and STIs ⁽⁶⁾ and within the context of the sexual and reproductive health recommendations ⁽⁷⁾, the High Council of Public Health (HCSP) noted that sexual health treatment was fragmented between various institutions and across various public health plans and policies without any real connections between them. It recommends implementing a “National Sexual Health Strategy to ensure physical, emotional, mental and social well-being in relation to sexuality from birth to old age for the entire population”.

Likewise, the report on sexuality education released by the High Council for Equality between Women and Men ⁽⁸⁾ highlights the fragmentation of this policy across multiple institutions and stakeholders, and calls for the implementation of a national action plan and the interministerial coordination of effective sexuality education targeting all youth socialisation areas.

The National Sexual Health Strategy is based in particular on the public notice following the recommendations for the prevention and treatment of STIs in adolescents and young adults released by the National Council of AIDS and Hepatitis Viruses in February 2017 ⁽¹⁰⁾.

The global sexual health indicators of the French population are satisfactory compared to many countries: the main indicators of the aims of good sexual health were achieved in part:

- **Autonomy** (having the ability to conceive children and the freedom to decide to conceive them): 80% of women aged 15 to 49 are using a method of contraception ⁽³⁰⁾
- **Safety**: more than 80% of adolescents aged 15 to 25 use condoms during their first sexual relationship ⁽³⁰⁾ ;
- **Satisfaction**: 88% of both women and men considered their sex life as “very good” or “satisfactory” ⁽¹⁸⁾ ;

However, many indicators associated with sexual health are unsatisfactory and show that approaches centred on the individual and pathologies have reached their limits of effectiveness (Annex 2). We are thus able to cite the most significant of these:

- **25% of schools state they have not implemented any sexuality education measures** despite the legal requirement, indicating that sexuality education is still being insufficiently implemented according to the barometer produced by the High Council for Equality ⁽⁸⁾;
- **one third of pregnancies are unplanned and result in abortion in 6 out of 10 cases**; despite an increased level of contraception, the number of unwanted pregnancies remains too high, particularly those resulting in abortions ⁽¹¹⁾;
- **a 10% increase in STIs among 15-24 years olds between 2012 and 2014 and among vulnerable populations** ⁽¹⁰⁾, STIs are increasing, and especially affecting adolescents;
- close to **6,000 new cases of HIV in 2015**; even though the HIV epidemic has remained stable overall since 2007 ⁽¹²⁾ the figure is still alarming among MSM (who represent 43% of new cases of HIV in France) and significant among foreign-born heterosexuals (38%) ⁽¹³⁾

- **HBV vaccination coverage is insufficient among exposed adolescents and adults** (43% of adolescents aged 15 (2009)) and HPV vaccination coverage is also too low (28.3%) of young women aged 16)⁽¹⁴⁾;
- 1 out of 7 women and 1 out of 25 men state they have been subjected to a form of **sexual violence** during their life ⁽¹⁵⁾;
- **social discrimination**, in particular inequalities between men and women, homophobia (31% of MSM have been victims of homophobic acts within the last 12 months (2012) ⁽¹⁶⁾), which affects their mental health and causes low self-esteem;
- **difficulties associated with sexuality** vary from 35 to 65% depending on age and sex. Sexual disorders and dysfunctions vary (13% to 38%) depending on age, sex and associated comorbidities ⁽¹⁷⁾.

Promoting an approach that integrates the determinants of sexual health

Achieving satisfying, autonomous and responsible human sexuality is dependent on different determinants (individual, interpersonal, structural and environmental) which directly affect the sexual behaviour of people (18) (19) (20). This public health strategy linked with sexual intimacy must be able to envisage common roots in social groups with different backgrounds while determining what is specific to them at the same time. The central and multidisciplinary approach to human rights in the Sexual Health Strategy will allow us to take the appropriate action with regard to the health of the population.

Scientific progress and its applications alone is not enough to improve health indicators. Taking action before problems occur by targeting all of the determinants which influence the health of an individual, communities or a population - either positively or negatively - is indispensable. The biomedical approach to sexuality should be linked with individual approaches that integrate the four dimensions of sexual health: psycho-societal, community, environmental and structural in accordance with human rights.

The first field of determinants of sexual health is individual. It comprises strategies that systematically integrate physical/biological dimensions, socio-economic characteristics, and social/emotional/interpersonal/mental skills.

The second field of determinants of sexual health is community. It comprises strategies that integrate the direct influences and impacts on the levels of: family, friends, local community, school, work and home.

The third field of determinants of sexual health is structural and contextual. It comprises, on the one hand, educational, health and social healthcare systems, the land usage, media and communication technologies and the political, legislative, economic, demographic, socio-cultural and cultural contexts on the other hand.

Within its scope, the National Sexual Health Strategy must therefore use a group of multidisciplinary and cross-sector elements that directly impact the determinants of sexual health and act upon the cumulative weaknesses, with the aim of rectifying social and regional health inequalities.

The elements used, the most important of which are those relating to primary prevention (information, education, communication to promote sexual health), aim to influence the main determinants of sexual health - individual and social. They are used in particular to develop the social perceptions of gender and sexual orientation present in society and reflected in healthcare, and which interfere with the development of satisfying, autonomous and safe individual sexuality, and which comes about through the respect and reciprocity of human relations.

To better address the sexual health of the population, the joint commitment of all stakeholders is required in order to understand the significance of the determinants in connection with human rights, and thus to be able to act effectively. Participation of all communities and communication between these are vital conditions for improving sexual health indicators (7).

Sexual health also represents a determinant of overall health, and as such also includes treatment of sexual dysfunctions that impact sexual wellbeing which arises during different life events such as pregnancy, non-transmissible chronic diseases (diabetes, cancer, arterial hypertension, etc.), aging (menopause) and disabilities.

Mobilising all resources

The National Sexual Health Strategy, managed by a national committee, has been designed as a framework that defines the main national objectives shared across the interministerial level to promote better sexual health.

To achieve this, it will mobilise different national and local plans for implementation in the operational strategies of the different stakeholders: central administrations of the ministries concerned and their decentralised services, along with the public agencies and facilities concerned, local authorities, the health insurance network, professionals, associations and stakeholders concerned, in particular the Committees for the Coordination of the Fight against HIV (COREVIH).

The strategy will mobilise the vital stakeholders, namely the Regional Health Agencies (ARS) to organise the short-term and medium-term operational objectives within the framework of the Regional Health Projects (PRS).

Healthcare services and professionals - in particular those in primary care - have a vital role to play in the structure of users' healthcare pathways and should be encouraged in their efforts to coordinate and develop skills, in the field of sexual health as well.

It is also important to remember the place of associations in their capacity as partners of the State and local authorities with regard to their role in the joint construction of public policies. As specified in the Prime Minister's circular, no. 5811-SG of 29 September 2015 on new links between public authorities and the associations "at the heart of civil society, associations have an essential place in the collective life of the Nation and the working of our societal model". The circular furthermore stresses that "it is vital that we bolster the role of associations in creating original and relevant solutions to the current issues".

The time frame of the national health strategy

The National Sexual Health Strategy is designed to be long term, in keeping with the United Nation's Sustainable Development Goals (SDGs) for 2030 ⁽¹⁸⁾ (annex 4).

The numerical indicators to be attained midway - in 2023 - are defined in order to measure the progress and to ensure the strategy is being monitored, in keeping with the agenda of the new European health policy framework, "Health 2020", and with the agenda of the five-year regional health projects laid down by the Regional Health Agencies.

A regular evaluation process over the long term is set up so it is possible to adjust the priorities when there are developments in knowledge.

Strategic approaches

The strategic approaches of the Sexual Health Strategy address six priorities:

- **PRIORITY I:** Invest in the promotion of sexual health, in particular among young people, as part of an overall and positive approach;
- **PRIORITY II:** Improve the health pathway with regard to STIs, including HIV and hepatitis viruses: prevention, screening, and treatment;
- **PRIORITY III:** Improve reproductive health;
- **PRIORITY IV:** Meet the specific needs of the most vulnerable populations;
- **PRIORITY V:** Promote research, knowledge and innovation in matters of sexual health;
- **PRIORITY VI:** Take into account the specific characteristics of the Overseas Territories to implement the Sexual Health Strategy as a whole.

PRIORITY I - INVEST IN THE PROMOTION OF SEXUAL HEALTH, IN PARTICULAR AMONG YOUNG PEOPLE, AS PART OF AN OVERALL AND POSITIVE APPROACH

Vision	<ul style="list-style-type: none"> Act early with young people to allow each of them to make informed, responsible decisions when it comes to their sexual health
Priorities	<ul style="list-style-type: none"> Educate people from a young age in matters of relationships and sexuality in compliance with human rights Improve the impact of sexual health information, in particular among young people Increase the sexual health training of healthcare and medico-social professionals as well as those in the educational and legal sectors.
Targets for 2023	<ul style="list-style-type: none"> 100% of young people have received high-quality education in sexuality and the associated risks (STIs, unwanted pregnancies) throughout their school curriculum 100% of basic or continued training bodies for healthcare professionals offer complete overall sexual health training

To allow the whole population to make informed, responsible decisions with regard to their sexual health, information, education and communication relating to sexual health are of paramount importance.

They should aim to improve individuals' level of knowledge, yet also promote the development of attitudes, behaviour and skills. The content should prioritise promoting equality between men and women, self-respect and respect for others, the fight against prejudice and discrimination towards lesbian, gay, bisexual, transgender and intersex (LGBTI) people, the fight against HIV phobia and against sexual violence, the prevention of STIs and HIV, and information on contraception and abortion. They should also enable different audiences to identify and address professional structures and resources depending on their needs.

Programmes and resources for information, education and communication should be adapted to different stages of life and to each public group, in particular those with disabilities and other vulnerable public groups.

AIM 1 - EDUCATE YOUNG PEOPLE ON SEXUALITY, SEXUAL HEALTH AND INTERPERSONAL RELATIONSHIPS

The challenge is to encourage and step up the implementation of multidisciplinary education relating to sexuality. This is not supposed to limit the transfer of biological knowledge, rather to be committed to developing the psycho-social skills of children, adolescents and young adults, while simultaneously helping them build a body of knowledge in their thinking on mutual respect, quality between boys and girls, reciprocity and consent to relations with another person. The development of their critical thinking, particularly the analysis of social models and roles (stereotypes) (17) driven by the media and social networks should be highlighted. School plays a vital role in health education, identification, prevention and information. Sexuality education should generally involve all facilities for children and adolescents, and should include parental education. Particular attention will be given to adolescents under 15 years old, 20% of whom have already become sexually active.

1. Draw on public health framework agreements to implement sexuality and sexual health education in all educational establishments

- **Implement sexuality education in the health education pathway (3) at all school levels, from nursery school to college.** Sexuality education develops through all lessons, in particular biology, and through pupils' school life. Integrated from now on in the primary objectives of the health education pathway implemented by the national education, sexuality education must continue to be rolled out with a view to achieving effective implementation in all educational establishments, and the results of this programme should be evaluated in terms of its objectives;
- **Draw on the public health partnership's framework agreement on National/Health Education and the national plan for student life** to encourage offering sexual health services in universities and university services for preventative medicine and the promotion of health (SUMPPS). The educational policy on matters of sexual health in universities should be developed with the support of the University Health Services (SSU);
- **Establish an Agricultural/Healthcare framework partnership agreement on public health** to continue the educational policy set up within the establishments relating to the Ministry of Agriculture.

2. Develop sexual health education aimed at adolescents outside of the school or university curriculum.

- **Integrate sexuality education in the formalised routes of support into employment and independence, in particular within the “Young people’s guarantee” programme¹;**

The aim is to integrate awareness of sexuality into this pathway, guided by professionals trained in sexual education.

- **Engage awareness raising within the context of sporting and/or extracurricular cultural activities,** in particular on preventing sexism and homophobia as well as sexual violence;
- **Establish a framework partnership agreement for public health with the Directorate for the legal protection of young people/Health that can be developed and tailored for underage people monitored by the legal protection of young people** regarding education on day-to-day living, sexual health and preventing risks associated with sexual practices;
- **Make sex lives, relationships and civic life accessible and adapted to young people living in institutions,** in particular young people living with disabilities.
- **Adapt and certify sexual education tools** aimed at young men, women or trans people who identify as part of the LGBTI community.

3. Improve the visibility of resources and tools for information made available to educational teams and those involved in working with young people.

- **Boost and promote the “Sexual education” portal on the site Eduscol²,** a portal with information and guidance dedicated to circulating educational resources;
- **Supply approved guides for people working with young audiences and specific groups³** (for example “sexist and sexual behaviours”, “guide for parties involved in sexuality education”, “usage guide for organisers and directors of holiday and activity centres: prevention and management of violent situations”).

4. Develop measures to approach prevention facilities (CeGIDD, CPEF etc.) in schools but also in living environments, informal places for increasing young people’s knowledge in their setting and spreading adapted prevention information.

¹ Article 46 of law no. 2016-1088 of 8 August 2016 essentially provides for the Young People’s Guarantee to be included in the French Labour Code as part of a formalised pathway to support young vulnerable people entering the workplace and becoming independent. The Young People’s Guarantee shall become a right for young people from 18 to 25 from 1 January 2017.

² <http://eduscol.education.fr/>

³ Recommendation no. 20, Systematically spreading sexuality education reference tools aimed at involved parties, educators, young people and parents, HCE - Report on sexuality education

AIM 2 - IMPROVE SEXUAL HEALTH INFORMATION USING NEW COMMUNICATION TOOLS

Sexual health information is in addition to sexuality education. It addresses the general population, in particular young people, as well as specific groups and should have an effect on the determinants of sexual health. This information is founded on the respect of human rights and the values that support them, and integrates - in addition to information on the biomedical resources required to protect oneself, to be screened or treated - information on personal and social skills, attitudes and values that support sexual health.

5. Make reliable and up-to-date sexual health information resources available to everyone in a single database (Public Health Information Service (SPIS)).

E-health provides the users with the opportunity to access scientific and medical information, to better understand how to navigate the health pathway and become an active participant in their healthcare. The Public Health Information Service (SPIS) - the main part of which will be devoted to young people - will be the main driver, offering the expected guarantees of information that is reliable and accessible to members of the public.

6. Mobilise methods of communication, in particular social marketing (21) to encourage behaviour that is favourable to health for more effective communication and prevention.

- **Improve knowledge and the adoption of preventative practices by young people becoming sexually active.** For example, the site onsexprime.fr, aimed at young people, developed by the National Public Health Agency (ANSP) provides interactive educational content as well as tools to assist in managing one's sexual health;
- **Support and promote new educational tools, in particular digital** tools furthering behavioural changes by means of recreational or educational tools that aim to promote independence, satisfaction and safety in connection with sexuality for adults and young people.

7. Promote remote sexual health help services by offering interactive tools to direct users to the closest resources and facilities for their needs.

- **Create the “sexual health” component of the “Guide to rights” (Boussole des droits) aimed at young people.**

Developed as part of a plan prioritising youth, the Guide to Rights is a geo-localised digital platform that gives all young people an answer and/or orients them to a nearby service depending on their situation at a given moment, and can provide answers on four topics: housing, work, training and health. The aim is to develop a section on sexual health within the health topic;

- **Spread messages about prevention on social networks and geo-localised meetup applications;**
- Support and promote remote services integrating information, education, prevention tools and screening with regard to sexual health to encourage independence (STI screening, information on contraception, etc.);

8. Limit and take action against potentially sensitive content that the population may be exposed to, in particular young people.

- **With regard to prevention in matters of sexual health, take into account diversity in sexuality, identity and sexual orientation and the associated discrimination.**
- Act against misinformation in sexual health matters and normative representations relating to gender, sexual orientation and sexuality driven by the media and social networks.
- **Create a commitment charter aimed at the media and publicists on the fight against all types of visual discrimination** (body uniformity, gender stereotypes and relating to sexual orientation).
- **Adapt and roll out the commitment charter to users of pornographic or meetup sites, commercial places for sexual encounters** (wide-ranging prevention, reduction of risks and human rights).
- **Make legislation, protecting minors from exposure to content of a pornographic nature, effective.**
- **Study the conditions that contribute to the spreading of content and cinematic or audio-visual work of a pornographic nature**, with the aim of supporting sexual health education measures targeting people who use these entertainment and meeting methods.

AIM 3 - INCREASE SEXUAL HEALTH TRAINING FOR HEALTHCARE, MEDICO-SOCIAL, EDUCATIONAL, LEGAL AND MEDIA PROFESSIONALS WORKING IN THE FIELD OF SEXUAL HEALTH AND SEXUALITY EDUCATION

Improving professional practices needs to be defined in academic terms and reinforced by giving healthcare professionals training in sexual health, in particular professionals working in primary care (general practitioners, pharmacists, midwives, nurses etc.), users' first port of call in the healthcare system, and professionals in the medico-social and social sector (marriage and family counsellors in particular).

The aim is to provide these professionals with a common platform of scientific, psycho-social and legal knowledge as well as to teach them how to communicate effectively on topics related to sexuality with empathy and without judgement, thus helping them to improve their communication skills and adapt their advice, diagnosis and treatment of users. It will also improve healthcare professionals' knowledge, in particular those in primary care, of the characteristics and specific needs of the target populations, particularly the overlap with addiction and methods of communication such as "short communication" relating to sexuality.⁽²²⁾

Likewise, in the field of education, initial and continued training for people involved in sexuality education at a school level is still insufficient and should be improved. An essential factor in educational success, training educational staff in sexuality education sets up teams of shared skills that are likely to analyse the needs of pupils, to create an overall progressive educational approach that is adapted to the pupils.

9. Reinforce the approach using multidisciplinary training and further develop these: healthcare professionals (doctors, midwives, nurses, pharmacists), professionals in medico-social sectors, in particular facilities for elderly people or those with disabilities, as well as educational, legal and media facilities.

10. Review the training received by healthcare professionals within an overall approach to sexual health.

- **Integrate the topic of sexual health as part of the reform of the 3rd stage of studies for healthcare professionals** (National Commission for Maieutic, Medical, Odontology and Pharmacy Studies (CNEMMOP));
- **Develop sexual health training models** for the initial training of doctors, pharmacists, midwives and nurses using the existing training model for maieutic studies;
- **Develop continuous training within the field of sexual health, communication techniques for discussing sexuality**, on the platform of the national agency for the continuous development of healthcare professionals;
- **Offer training placements at CeGIDD** to doctors, nurses, midwives, marriage and family counsellors, like the CPEF, mother and child welfare (MCW) services and family planning centres;
- **Train professionals working in primary care** (including emergency services) on sexual and psychological issues within the key populations at an increased risk (e.g. chemsex);
- **Promote innovative educational tools** on protecting victims of violence.

11. Increase the sexual health training of educators working in National Education and the Ministry of Agriculture (teachers and managers).

- Make sexual health modules compulsory in Teaching and Education Training Colleges (ESPE), with both initial and continued training;
- Allow for practical analysis and re-appropriation of knowledge in continued training.

12. Integrate a module on sexuality education as part of the training

Given to staff supervising support given to minors, educators in general, and in particular in the context of the Legal Protection of Young People (PJJ) and Child Welfare (ASE), training for the Child Protection Certificate for working with young people (BAFA) and the Child Protection Certificate for managing centres that host young people (BAFD).

AIM 4 - REINFORCE PARENTS' SKILLS

13. Reinforce parents' skills in educating their children on matters of sexual health

by providing them with suitable tools and leaning on existing means: within National Education (Parent Areas 'espaces parents', Parent's Schoolbag 'mallette des parents, Eduscol etc.) as part of the state-funded family benefits (CAF), the town council, via community health mediators etc.

PRIORITY II - IMPROVE THE HEALTHCARE PATHWAY IN TERMS OF STIs INCLUDING HIV AND HEPATITIS VIRUSES: PREVENTION, SCREENING, AND TREATMENT

Vision	<ul style="list-style-type: none"> • No new HIV infections, no deaths linked to AIDS and zero discrimination • Eliminate STI epidemics along with major public health problems • People living with HIV can live in good health for a long time
Priorities	<ul style="list-style-type: none"> • Develop an overall and positive approach centred on all of the dimensions and determinants of sexual health • Develop and promote various prevention methods to end the HIV epidemic as a threat to public health by 2030. Increase the sexual health training of healthcare and medico-social professionals as well as those in the educational and legal sectors. • Identify people who are unaware of their HIV positive status and putting off being screened to rapidly reduce the “hidden epidemic” • Reverse the trend of the most common STIs and/or the most serious (syphilis, gonorrhoea, chlamydia, lymphogranuloma venereum (LGV)) • Reduce the time between infection and treatment, boosting rapid access to HIV, HBV, HCV, STI screening and treatments • Develop HBV/HPV vaccines and ensure these are up-to-date among adolescents • Maintain access to effective therapeutics against the main STIs and fight against antimicrobial resistance • Guarantee access to suitable healthcare for key populations
Targets for 2023	<ul style="list-style-type: none"> • In 2020, 95% of people living with HIV are aware of their HIV status • In 2020, 95% of all people tested who are infected with HIV receive the recommended anti-retroviral treatment • In 2020, 95% of people receiving anti-retroviral treatment have a lasting undetectable viral load • In 2023, 75% of adolescents covered by the hepatitis B vaccination (95% in 2030) • In 2023, 60% of adolescents covered by the HPV vaccination (80% in 2030) • Reduce the incidence of the most common and most serious STIs: (syphilis, gonorrhoea, chlamydia, lymphogranuloma venereum (LGV) (reference year: 2023)

In France, the number of cases of HIV discovered ⁽²³⁾ was estimated to be close to 6,000 in 2015; this number having been stable since 2007. Men who have sex with men (MSM) and foreign-born heterosexuals (3/4 of whom were born in a country in sub-Saharan Africa) are still the two most affected groups and represent 43% and 38% of new cases detected in 2015, respectively. Heterosexuals born in France and intravenous drug users (IDU) make up 16% and 2%, respectively.

The number of new cases of HIV-positive people is still not falling among MSM, contrary to what is observed among heterosexuals, men or women, who were born in France or abroad. Approximately 2,600 MSM tested positive for HIV in 2015.

An increased number of early diagnoses was seen in 2015, whereby overall HIV screening activities increased by 3% compared to 2013 (5.4 million blood tests performed in laboratories in 2015).

The number of rapid diagnostic tests (RDTs) performed in 2015 ⁽¹⁹⁾ as part of the “community screening” programme was 62,200, similar to that of 2014. It is still marginal compared to the overall screening programme. In contrast, by targeting the populations that are particularly exposed to HIV (30% of MSM and 31% of migrants in 2015), the rate of positive cases is higher.

HIV screening should be intensified further in these populations to reduce the proportions of people who are unaware of their HIV positive status. This should be made possible with a diversified range of tools (traditional laboratory tests, community RDTs, sale of self-tests in pharmacies, providing free self-tests in authorised facilities), and dedicated places, such as the CeGIDD, and the CPEF.

In 2013, the proportion of people diagnosed as HIV positive was 84%. 90% of people diagnosed were treated and 90% of those treated for at least 6 months have an undetectable viral load⁽²³⁾.

For several years, the number of diagnosed cases of other sexually transmitted infections (syphilis, gonorrhoea, chlamydia, lymphogranuloma venereum) has been greatly increasing⁽²⁴⁾. Bacterial STIs (early syphilis, gonococcal infections, and lymphogranuloma venereum - LGV) continue to increase, in particular among MSM ⁽²⁴⁾. In a context of combined HIV prevention (condoms, screening, PrEP, PEP, TasP), early screening for bacterial STIs followed by appropriate treatment is indispensable in terms of stopping their transmission.

The measures to be developed as a priority for the populations most exposed to STIs (MSM, WSW, trans people and people involved in prostitution (PIP), incarcerated people), the populations most exposed to hepatitis viruses (people from endemic regions, MSM, drug users), the populations most exposed to HIV (MSM, migrants originating from sub-Saharan Africa, drug users and people involved in prostitution, incarcerated people) are expanded on in priority IV.

The National Sexual Health Strategy relies on implementing methods of behavioural and biomedical prevention, screening and treatment that are specific to HIV while maintaining and reinforcing a policy of reducing the other more frequent STIs.

AIM 1 - REINFORCE AND DIVERSIFY STI AND HIV PREVENTION

It is the social circumstances surrounding sexuality which create vulnerable situations that can be prevented (17). An individual's concerns regarding prevention should be approached in terms of interpersonal and social circumstances. Prevention is based on a renewed message of diverse methods of prevention within an overall approach to sexual health. This approach, which was proposed in light of the partial failure of HIV/AIDS (25), is currently the main priority in the prevention of STIs and HIV. It develops the prevention approaches that combine socio-behavioural and biomedical dimensions, screening adapted to the person, the moment, and the situation, with the aim of reducing exposure to STIs and HIV.

Condoms as a basic tool: widely accessible, condoms are the most common preventative tool. It is still the basic method for protecting oneself and others against HIV and STIs and prevent unwanted pregnancies.

Anti-retroviral treatments are used to reduce the transmission of HIV. **Post-Exposure Prophylaxis (PEP)** is an emergency preventative treatment that can greatly reduce the risk of HIV/AIDS transmission after being exposed to the risk of transmission of the virus. **Pre-Exposure Prophylaxis (PrEP)** is part of a varied strategy to prevent the transmission of HIV by sexual means that reduces the risk of contracting HIV for a period of exposure to a contamination risk. **Treatment as Prevention (TasP)** is a way of reducing the risk of transmitting the virus to a partner if the treatment for HIV is effective and the plasma viral load is undetectable for at least 6 months.

14. Continue to promote condoms as a basic tool (male and female).

- **Make the use of condoms accessible to everyone** by promoting them in conjunction with targeted educational, screening and psycho-social treatment programmes.
- **Develop and diversify "social marketing" of condoms using approaches specific to each key population;**
- **Make them more accessible and diversify the range** with more high-quality products, which are therefore more appealing;
- **Ensure they are readily available in colleges and secondary schools, universities** (condom machines, nurse's office) in good conditions.

15. Encourage repeated STI screening, including HIV, as a prevention tool

along with individual, repeated discussions that include - in addition to health education - brief intervention to reduce exposure to HIV and STIs.

AIM 2 - INCREASE STI VACCINATION COVERAGE FOR VACCINE PREVENTION

16. Offer vaccinations in accordance with the “general” vaccine recommendations and the “specific” vaccine recommendations for specific conditions (increased risk of complications, exposure or exposure at work), in particular vaccinations against the human papilloma virus (HPV) and hepatitis B infections.
17. Improve the vaccination coverage as part of HBV booster vaccinations:
 - Reinforce the promotion of the current recommendations for HBV booster vaccinations: older children and adolescents up to 15 years of age, as well as older adolescents and adults in accordance with the criteria for increased exposure risk defined in the vaccination schedule;
 - As a temporary measure, promote an extended HBV vaccination booster strategy, outside of the increased exposure risk groups, for the generation of young people under 30 who have not been vaccinated;
 - Redefine the resources and discourse for communicating about the HBV vaccination;
 - Cite the diphtheria, tetanus and polio vaccination given between 11 and 13 years as an opportunity to systematically offer a HBV vaccination booster;
 - Mobilise the following entities for the benefit of the booster strategy, taking into account the specific characteristics of young groups in care: CeGIDD, CPEF, healthcare centres involved in the treatment of populations in vulnerable situations, healthcare centres for young offenders;
 - Raise occupational health physicians’ awareness of the HBV vaccination when beginning an apprenticeship or in their first job.
18. Reduce the incidence and prevalence of HPV infections among adolescents and young adults:
 - Adopt a universal HPV vaccination strategy for girls and boys aged 11 to 13, including a booster vaccine for adolescents and young adults who have not been vaccinated.
19. Redefine the resources and discourse for communicating about the HPV vaccination;
 - Parents and adult educators: improve information on the risk/benefit ratio by focusing beyond the neoplastic risks on the negative impact of anogenital warts on sexual health.
 - Young people: adapt information to the specific ages and spread this throughout the facilities that use this information.
 - Healthcare and education professionals: improve the knowledge of pathologies associated with this infection and improve the ability to respond to concerns that are expressed and to promote sexual health.

AIM 3 - IMPROVE SCREENING OF SEXUALLY TRANSMITTED INFECTIONS AS PART OF AN OVERALL APPROACH TO SEXUAL HEALTH

All screening measures will take into account the new screening strategies in line with recommendations and technical developments.

20. Encourage repeated screening among the populations that are most exposed to HIV by intensifying screening offers: mobilisation of all stakeholders (primary healthcare professionals, biomedical laboratories, associations, prevention and screening facilities, CeGIDD, CPEF).

- **Develop new approaches that promote the fact they are close to key populations, encouraging “approachable” measures**, or using smart phones or other paperless communication.
- **Support community screening of HIV and/or HCV** guaranteed by associations involved in health prevention or reduction of the risks and damage related to psychotropic substance consumption.
- Encourage the participation of structures for prevention, risk reduction and **support of groups in difficulty (CSAPA/CAARUD/Clinics for Young Users (CJC))** in screening for HCV and HIV infections among drug users, in particular through the use of RDTs.
- **Develop methods to encourage population groups who are the latest to come for screening to do so** (men born in sub-Saharan Africa for HIV and HBV in particular) and who are most unaware of their status (12);
- **Encourage the use of self-tests for HIV screening**: by offering these free at CeGIDD, CPEF, CSAPA, CAARUD, CJC and community centres that have already been authorised to carry out RDT screening, by developing regulations to make these accessible in pharmacies;
- **Adjust screening hours to suit the way of life of the key populations to be screened**;
- **Ensure the best care for STI screening by developing the laboratory services covered by health insurance.**

21. Investigate the option and feasibility of lifting the obligation of an adult accompanying a minor who wants to keep their health condition confidential in terms of preventing STI screening and treatment thereof.

22. Increase screening for chlamydia infections among young women under 25, men aged under 30 and those with multiple partners.

23. Encourage the prevention of cervical cancer (see other types of cancer)

by means of vaccination, HPV screening including primary screening and smear tests for cervical cancer for people identified to be at risk, make smear tests widespread across the country and develop sexual health programmes for lesbians who are less likely to be screened, in particular for cervical cancer. Support the prevention of anal and oropharyngeal cancers by screening and vaccinations.

24. Systematically offer screening for STIs during abortion proceedings.

25. Increase the offers of screening for future parents when trying for a baby or when pregnant.

26. Investigate the possibility of expanding the transfer of screening skills.

27. Investigate the feasibility and acceptability of notifying partner(s) and implement programmes to support those notifying their partner(s).

AIM 4 - IMPROVE MEDICAL CARE FOR STIs AND HIV

28. Improve the sexual health pathway

- **Reinforce the primary care professionals'** - in particular general practitioners' role in the fight against STIs, in particular among young people, by mobilising conventional tools (remuneration for meeting public health targets (ROSP), detailed consultations);
- **Encourage stakeholders involved in prevention, screening and care of sexual health matters across the regions**, leaning on the resources of the law on the modernisation of our healthcare system, and in particular the primary care teams and professional regional healthcare communities;
- **Encourage associative and community stakeholders and health mediators to become involved in sexual health**;
- **Promote medical coordination in situations deemed "complex"**: the health pathway is considered complex when the health condition, disability or social situation of the patient requires the intervention of several types of healthcare, social or medico-social professionals (art. L. 6327-1 of the French Public Health Code);
- **Support COREVIH in improving the health pathway.**

29. Facilitate the therapeutic and prompt care of people living with HIV (PLHIV) or hepatitis (with the aim of reducing the individual morbidity and mortality and the risk of transmitting the virus (treatment as a prevention tool)).

- **Begin all people living with HIV and/or hepatitis viruses on anti-retroviral/anti-viral therapy in line with the recommendations**, finding a solution for the main inequalities regarding access to treatment: access to rights bearing on health cover, residence permits, accommodation, transport, lack of security, etc., and by fighting against discrimination;
- **Provide effective treatment access to all people living with HIV or HCV** using strategies aimed at optimising adherence to treatment/observance, acceptability as well as continuity of care;
- **Fight against refusal of care** with the help of a reporting system and training professionals.

30. Facilitate assistance from interpreters for non-French speakers and/or health mediation for groups in vulnerable positions using reference documents from the National Health Authority on good practices on the use of interpreting or health mediation to improve access to rights, prevention methods and care for people far removed from healthcare systems, taking their specific characteristics into account.

AIM 5 - IMPROVE MEDICO-SOCIAL AND SOCIAL SUPPORT, PROMOTE ACCESS TO RIGHTS TO FIGHT AGAINST DISCRIMINATION EXPERIENCED BY PEOPLE LIVING WITH HIV AND VULNERABLE POPULATIONS

31. Improve housing and accommodation options for people with HIV or hepatitis

- **Adapt the care capacity and the treatment in the assisted therapeutic living facilities (ACT) to people's needs;**
- **Experiment with alternative options** for therapeutic assisted living facilities
- **Promote solutions that enable people to continue living in their home** with appropriate medico-social support;
- **Ensure there are private spaces within the social accommodation facilities** for those being cared for.

32. Ensure populations in a vulnerable legal or administrative situation have access to care

- **Ensure the valid right to be granted leave to remain and work over several years** for foreigners with serious illnesses living in France, including those affected by HIV and/or hepatitis viruses who would not effectively receive the appropriate continuity of medical care in their country of origin;
- **Make sure that the rights available to foreigners who have the right to remain for multiple years due to their state of health are not subjected to any discrimination** (access to residence card, right to work, etc.);
- **Ensure that all foreigners have basic and supplementary health insurance**, regardless of their administrative status, to allow them effective access to preventative healthcare and treatment;
- **Ensure their administrative residence status is effective** with the municipal social action centres or intermunicipal social action centres (CCAS or CICAS).

33. Fight against stigmatisation and discrimination based on health status (serological status), sex, sexual orientation, gender identity nationality that is ongoing and can affect one's social, professional and private life, and contribute to isolation, including among the most affected communities.

- With a view to promoting good health, assure that an HIV positive person is fully involved in prevention and works on the prejudices against PLHIV, in particular the ways of transmitting the virus;
- Encourage actions that aim to reduce discrimination on a medical level, in particular the practice of refusing care.

34. Encourage the access to rights.

- **Ensure the decision-making criteria** of the Commission of rights and independence of people with disabilities (CDAPH) are standardised, in particular **concerning benefits awarded to adults with disabilities (AAH)** by the Departmental Homes for People with disabilities (MPDH), particularly for people who have been infected for a number of years, those with multiple pathologies and those suffering from the effects of the first anti-retroviral treatment;
- **Recognise those with disabilities that have the capacity to work**, but have difficulties carrying out certain types of professional activities due to health problems (HIV, hepatitis viruses, chronic illnesses etc.);
- **Facilitate access, keeping and returning to work and the professional integration of people living with HIV and/or hepatitis viruses;**
- **Ensure that everyone has basic and supplementary health insurance** with no breaks in treatment to enable effective access to preventative healthcare and treatment.

35. Take into account and anticipate the aging of the population living with HIV

- Improve the prevention and screening of comorbidities ⁽²⁶⁾;
- **Improve the solutions with regard to disabilities or the loss of independence** linked with HIV and/or hepatitis viruses;
- **Encourage approaches that are respectful to sexual orientation by taking action with healthcare and social professionals in contact with the aging LGBTI population or those with disabilities.**

36. Improve people's access to finance who are living with HIV

- **Guarantee people living with HIV (PLHIV) and their families have good access to insurance and finance**, access which takes into account scientific progress with regard to care.

PRIORITY III - IMPROVE REPRODUCTIVE HEALTH

In compliance with the European Convention on Human Rights, the State is responsible for protecting and respecting the people's rights in matters of reproductive health. Reproductive health entails people having a satisfying sex life in complete safety with the ability and freedom to decide to conceive children or not, if and when they want.

Within the National Sexual Health Strategy, reproductive health includes contraception, abortion and preventing infertility outside of medically-assisted reproduction.

Medically-assisted reproduction, pregnancy and the monitoring thereof, childbirth, and perinatal matters are or will be handled in other public health plans in connection with this strategy.

Vision	<ul style="list-style-type: none"> ● Guarantee that people who choose to conceive children are able to if and when they want, as part of satisfying, responsible and safe sexuality ● Allow women and men to choose safe, effective, acceptable and accessible methods of controlling fertility.
Priorities	<ul style="list-style-type: none"> ● Reduce the number of unwanted and unplanned pregnancies⁴ ● Improve access to a range of suitable contraception methods
Targets for 2023	<ul style="list-style-type: none"> ● Reduce the number of unwanted/unplanned pregnancies in women by one third⁵ ● 90% of requests for abortion are handled within the periods defined by the National Health Authority (5 days) ● Keep congenital syphilis at a low level⁶ ● Facilitate access to permanent contraception (vasectomy, tubal ligation at 5%)

Contraception and abortion

There are approximately two births per woman on average over the course of life, of which 1.6 are planned, and 0.2 of which the woman "had not considered". 0.15 of pregnancies happen too early on as they were poorly planned, and 0.05 are unwanted because the woman does not want the child, and the average number of abortions that a woman has over the course of her life is 0.5⁽²⁷⁾.

In France, the increase of contraceptive cover between 1978 and 2010 reduced the number of unplanned pregnancies. The rate of 1.23 unplanned pregnancies during the period of 1973-1977 sank to 0.85 in the period 2005-2009 among women aged 18-44.⁷

The rate of contraception use remains high. In 2013, 45% of women aged 15 to 49 that were neither sterilised nor pregnant and having sexual relations but not wanting children used oral contraception, and only 5% were using other hormonal methods. One out of five women used an intrauterine device (IUD), the majority of which already having two or more children, 12% used condoms, whereas the rate of sterilisation was low (4%) ⁽²⁸⁾.

⁴ "Planned or expected pregnancies" include: pregnancies "wanted at that moment or wanted "earlier". "Poorly planned pregnancies" are pregnancies that were "wanted later on" or women "who had not thought about it" or the pregnancy "was not wanted at all" (this last category equates to unwanted pregnancies).

⁵ Rate of unplanned pregnancies at 0.85 in this period 2005-2009 among women aged 18-44

⁶ Title CIM 10 Congenital syphilis (A50) created using French PMSI (medical institution software) statistics

⁷ Effectiveness of Family Planning Policies : The Abortion Paradox

The French conventional contraceptive model is characterised by the widespread use of condoms at the start of one's sex life, use of the pill once the sex life becomes regularised, and the use of the coil once couples have had the children they want. Since 2013, this contraceptive usage is moving slowly towards a more diversified range of methods used, although female contraception is still largely dominated by oral hormones (11). Male contraception is virtually absent from this landscape(23). Sterilisation as contraception is authorised by law no. 2001-588 of 4 July 2001 but remains hardly used in France, in particular among men, unlike other countries on the same socioeconomic level (United Kingdom, the Netherlands, Canada, Germany).

The law of 17 January 1975 on abortion permitted abortion for the first time in France. Abortion is a human right that must be reiterated and reaffirmed. In France, the rate of abortions has remained stable for 10 years, at approximately 220,000 abortions per year(30). There are differences between different age groups. The highest rate is among young women under 30. Rates are also higher in certain metropolitan regions, such as the regions Île-de-France, Provence-Alpes-Côte d'Azur and in the Overseas Territories. Of the methods used, 57% of abortions in mainland France are medical abortions and 18% are performed outside of healthcare facilities. Half of abortions carried out in healthcare facilities were medical abortions(30).

Of the women who had an abortion, the majority were using a method of contraception that did not work (condom broke, forgot to take the pill). It should be noted that the use of emergency contraception, a method of contraception taken after sex to reduce unwanted pregnancies, has been increasing since 1999.

There are large socio-economic discrepancies in the use of contraceptive methods that is frequently linked to a lack of information and misrepresentations.(11,31,32)

Infertility

The WHO defines infertility as a couple's inability to reproduce after two years of unprotected sex.

The data we have on the infertility of couples in France is partial or inexact, primarily due to difficulties estimating across the general population. Despite this, studies have estimated that approximately 18% to 24% of couples who stop using a method of contraception will be affected by involuntary infertility for a period of one year. After 24 months, the proportion is 8% (27).

AIM 1 - GUARANTEE MEN AND WOMEN ACCESS TO THEIR CHOSEN METHODS OF CONTRACEPTION

AIM 1.1 - Expand information on contraception methods

37. Continue to promote the suitable contraceptive choice for each individual situation

- **Increase information** (in particular among healthcare professionals) **on all methods of contraception**, particularly those that may be an alternative to oral contraception;
- **Develop suitable support and tools** depending on the audience, in particular including cultural representations and barriers;
- Develop communication that takes into account the times of life that represent periods of less vigilance in terms of contraception (change of contraception, the very start and very end of fertile life, etc.);
- **Develop information on permanent female and male contraception.**

38. Provide information on contraceptive methods to people with disabilities (prescription, consultation, follow-up).

- **Develop communication tools adapted** to people with physical and psychological disabilities.

AIM 1.2 - Improve access to contraception, in particular in terms of the conventional range

39. Strengthen the involvement of doctors in prevention programmes and encouragement of healthcare

- **Make the first appointment with young girls aged 15 to 18 about contraception or sexually transmitted infection prevention effective**, as specified in the new medical convention of 2016.

40. Boost access to care

- **Offer accessible specialised resources to people with disabilities in healthcare facilities and medico-social facilities.**

41. Improve access to permanent female and male contraception

- **Mobilise professionals and consider incentives for increasing such procedures (e.g. vasectomy).**

42. Streamline the contraceptive pathway by developing local networks of professionals (private healthcare professionals, in particular treating physicians, health centres, CPEF, CeGIDD, pharmacists, registered nurses etc.) by leaning on the resources from the law on modernisation of our healthcare system.

AIM 1.3 - Mobilise all healthcare professionals and mobilise new stakeholders

43. Intensify the role of treating physicians in sexual health (identifying violence, primary and secondary prevention of STIs and HIV, access to suitable contraception, etc.)
44. Call on the skills of healthcare professionals in sexual health matters (general practitioners, gynaecologists and obstetricians, midwives, nurses, pharmacists).
45. Increase access to suitable contraception among people under 25 and among the poorest members of society.
 - **Allow University Health Services (SSU) to carry out consultations on controlling fertility.** In this respect, establishments could carry out medical consultations and prescribe contraception, screen for STIs and take responsibility for issues relating to sexuality.

AIM 1.4 - Develop knowledge

46. Improve access to permanent female and male contraception
 - **Investigate the stumbling blocks with regard to permanent contraception with a study involving the general population and one with professionals.**

AIM 2 - REDUCE UNPLANNED AND UNWANTED PREGNANCIES

47. Intensify initial and continued training of healthcare professionals (doctors, midwives, pharmacists).
 - **Include in the initial and continued training** different methods of contraception and an approach that favours giving the person the informed choice on their contraception method, training during breaks (IUD, new contraception types (implant, ring, etc.));
 - **Support associations in the development of continued training programmes** in the field of contraception, and surgical and medical abortion.
48. Ensure there is a wide range of options close by that meet the needs of the regions regarding sexuality and abortion.
 - **Increase the number of university healthcare centres that offer medical abortion** (and involve midwives as stakeholders);
 - Increase the number of 'maisons de santé' (multispecialty practices) that offer medical abortion;
 - **Re-evaluate the costs of medical or surgical abortion** to improve healthcare provision, in particular STI screening;
 - **Implement a call for projects** to help health centres comply with the HAS specifications for carrying out surgical abortions;
 - **Ensure that all CPEF are in a position to offer** medical abortions.

49. Investigate the possibilities of simplifying the abortion process in France by analysing the process in place in comparable countries.
 - **Update the good practice recommendations** in the field of abortion care.
50. Investigate the delegation of authority in contraception and medical abortion issues for nurses and marriage and family counsellors (CCF) trained under doctors within the context of an approved procedure.
51. Investigate a collaboration between healthcare professionals and stakeholders of associations to streamline the process of accessing abortion and contraception.
52. Facilitate access to reliable, reversible contraception⁸ commonly used.
 - **Investigate the conditions for medical insurance fully covering the cost of intrauterine devices and implants.**

AIM 3 - PREVENT INFERTILITY AMONG MEN AND WOMEN ACCORDING TO BEHAVIOURAL DETERMINANTS

53. Include infertility prevention among men and women in relation to behavioural determinants (being overweight/underweight, tobacco and alcohol consumption) in national plans and during the treatment of certain pathologies, in particular chronic illnesses (cancer, diabetes, hypertension etc.).
54. Preserve the natural fertility of women and men by strengthening and adapting methods of communication (information on periods of fertility, contraception options, birth spacing, consequences of undiagnosed STIs).

⁸ The Pearl Index of which is < 1 . The theoretical efficacy of a contraceptive method is measured using the Pearl Index, a theoretical index equal to the percentage of "accidental" pregnancies in one year of optimal use of the method(33).

PRIORITY IV - MEET THE SPECIFIC NEEDS OF THE MOST VULNERABLE POPULATIONS

Vision	<ul style="list-style-type: none">• Guarantee that everyone has the same rights in matters of sexual health and meet the specific needs of the most vulnerable populations and those most exposed to STIs
Priorities	<ul style="list-style-type: none">• Intensify prevention, screening and care for the populations the most exposed to HIV, HBV, HCV and STIs.• Take into account the sexuality of people with disabilities, elderly people and people with chronic diseases
Targets for 2023	<ul style="list-style-type: none">• Reduce the incidence of bacterial STIs among key populations• '95-95-95' objective for HIV in the key population• 80% vaccination coverage in the key populations

The general population and the populations with specific needs are affected by all fields and areas of the Sexual Health Strategy. This priority is aimed at action:

- for the populations that are the most exposed:
 - to sexual violence (women, gay, trans and lesbian people, people involved in prostitution, people in prison, etc.);
 - to STIs (young people, MSM, WSW, trans people and people involved in prostitution, people in prison);
 - to hepatitis (people from endemic regions, MSM, drug users (DU));
 - to HIV (MSM, migrants originating from sub-Saharan Africa, drug users and people involved in prostitution, people in prison);
 - to discrimination.
- for populations with determinants of vulnerability: MSM/migrants, trans/migrants, gay/chemsex.
- for populations from the Overseas Territories⁹ the most exposed to early and unplanned pregnancies, to metabolic disorders (obesity and most serious cases of excess weight cause an increased prevalence of diabetes, renal and cardiac insufficiency and higher numbers of cerebrovascular accidents), to sexually transmitted infections or addictive behaviours.

⁹ See Priority VI- Take into account the specific characteristics of the Overseas Territories to implement the Sexual Health Strategy as a whole

This specific approach is necessary to take into account the specific needs, associated in particular with one of the following factors:

- Excessive exposure to risks in groups with widespread prevalence (LGBTI, PIP, IV drug users etc.)
- Under-estimation of exposure to risks (seniors, people with disabilities);
- Unawareness of or administrative difficulties regarding access to care, health insurance (people in a vulnerable economic and social position, foreigners with an illegal or unstable administrative status in terms of the legislation on entering and remaining in France);
- Medical and psycho-social care and legal support on physical, sexual and/or psychological violence for the victims of violence or children exposed to this;
- Healthcare for the perpetrators of violence to prevent recurrence (relating to sexual violence, for example through resource centres to assist in supporting the perpetrators of sexual violence (CRAVS));
- Treatment of sexual disorders: chronic illnesses, addiction, aging, psychological disorders and physical disabilities.

Responding to these specific needs requires:

- Improving knowledge of the characteristics of key populations among professionals and stakeholders within the field of sexual health;
- Improving care, promoting and adopting a non-judgemental position in terms of different life pathways and sexual practices or practices associated with sexuality, such as consumption of psychoactive substances;
- Adapting information and prevention types;
- Combating discrimination;
- Effective application of the right to privacy;
- Involving the stakeholders concerned: associations, COREVIH, professionals in social fields, medical and paramedical staff/medical and medico-social facilities, educational experts;
- Implementation of strategies to reduce risks and damage;
- Expanded and tailored range of care options that are easy to access by populations;
- An intersectoral approach.

AIM 1 - INTENSIFY PREVENTION, SCREENING, ACCESS TO RIGHTS AND CARE FOR THE POPULATIONS THE MOST EXPOSED TO HIV, HBV, HCV AND STIs

AIM 1.1 - Aimed at men who have sex with men (MSM)

The number of new cases of HIV positive people is still not falling among MSM, contrary to what is observed among heterosexuals, men or women, who were born in France or abroad. Approximately 2,600 MSM tested positive for HIV in 2015 (12). The youngest, aged under 25, made up 13% of those who tested positive in 2013, and this proportion has increased significantly since 2003(13). The proportion of people aged 50 and above was 17% in 2013; this increased between 2003 and 2012. The incidence peak among those aged 50 and above requires particular vigilance.

This is also the population most affected by other STIs (syphilis, gonorrhoea, condyloma etc.)(24). There is still a very real risk of HIV and STIs for men who have sex with men, despite the efforts made since the start of the epidemic.

Furthermore, the HCSP (7) states that 49% of MSM have experienced a depressive episode over the course of their life (26% of under 25s had a depressive episode within the last 12 months), 19% have made at least one suicide attempt during their life, which is 5 times higher than the general population. Among the respondents, 27% stated they had taken anxiolytics and/or antidepressants and 31% had been victims of homophobic acts within the last 12 months. Young people or men in socially disadvantaged groups are more frequently rejected by their close friends and family or homophobic assaults (31). There are also features of psychological vulnerability for MSM in terms of sexual practices. This means in particular developing measures based on the principle of "approaching" the target groups:

55. Increase the vaccination coverage of MSM with an increased risk of exposure (meningococcus C, hepatitis A and B, HPV etc.) in line with the current recommendations.

56. Strengthen wide-ranging prevention

This strategy consists of communication focused on sexuality in the context of an individual's environment, detailed information on HIV transmission and prevention methods, promoting the use of condoms, regular screening for HIV and other sexually transmitted infections, knowing the HIV status of one's partner(s) and the use of Treatment as Prevention (TasP) by the HIV-positive partner, the use of PrEP and PET (post-exposure treatment).

- **Continue to promote condoms as a basic tool;**
- **Supporting and securing access to PrEP for key groups**, in the context of general practitioners being authorised to renew prescriptions for PrEP as of 1 March 2017;
- Implement specific monitoring of PrEP at national level, including supervision of people who have seroconverted while receiving PrEP for analysis into the acquisition and transmission of HIV resistance;
- **Facilitate access to post-exposition treatment against HIV and hepatitis B** by allowing CeGDID doctors to prescribe the required medication;
- **Better adapt combined prevention** used by priority groups to each individual situation, by means of targeted communication, particularly among young MSM people.

57. Facilitate access to community-based repeated screening by healthcare professionals, in CeGIDD, etc.

- **Implement and develop personal support interviews for** people at high risk of contracting HIV and STIs (episodes of STIs in the last 12 months, vulnerabilities exposing people to unprotected sexual relations, use of psychoactive drugs, etc.);
- **Support community HIV and/or HCV screening services provided by associations** involved in preventive healthcare and the reduction of risks and damages associated with the consumption of psychotropic substances;
- **Adapt the rapid screening services available to scientific developments and tools available;**
- **Promote STI (syphilis, gonorrhoea, etc.) screening** among this group;

58. Develop an overall sexual health strategy that takes into account mental health, other chronic diseases, and the reduction of risks and damages related to addiction

(ad hoc network of stakeholders or structures depending on the region). This must be based on coordination and sharing of good practices between healthcare professionals in communities, hospitals, CeGIDD, healthcare centres, stakeholders from associations, COREVIH, etc.

- **Work to reduce the risks and damages related to practices that involve consuming psychoactive substances in a sexual context ("chemsex")**, in that they contribute to maintaining the dynamic of the HIV epidemic and to the increase of HCV infections in the homosexual population;
- **Develop a specialised consultation service:** proctologists, sexologists, dermatovenereologists and urologists, hepatologists, taking into account the specific characteristics of MSM, in a healthcare pathway context.

59. Combat discrimination (7, 34).

Reduce inequalities in access to healthcare, particularly for PLWHA MSM;

Develop a multidisciplinary approach involving associations and institutions to combat discrimination.

AIM 1.2 - Aimed at trans people

A French study from 2010 (35) reveals the problems that trans people in France face in accessing healthcare and the incompatibility of some healthcare services expressed by this group. Few datasets exist on this group, despite it being a significantly disadvantaged one. Further studies are needed in order to improve knowledge in this respect and to therefore better target prevention and screening services.

A 2007 study conducted online shows that trans people differ from the general population in several respects(36):

- They live less often with a partner,
- They are less sexually active,
- They are exposed to more risks - half of those asked said that they never used condoms during intercourse with their main partner.

Regarding HIV screening, 21% of those interviewed said that they have never used it, and among those who had been tested, 5.7% declared themselves HIV positive. Lastly, 20% of participants said that they had stopped going to see a general practitioner for fear of being discriminated against owing to their being transgender, while 49% had been discriminated against or waived a right for fear of being discriminated against.

A prevalence of 6.9% of HIV infection among MtFs (male to female - people whose sex on their birth certificate is male but who identify with the female gender) confirms the seriousness of the epidemic in this sub-group, and all the more so when these people have been involved in prostitution and are of foreign origin (prevalence of 36.4%).

60. Combat discrimination and transphobia

- Step up the fight against discrimination and transphobia;
- Make the procedure for changing an individual's civil status more flexible.

61. Reinforce prevention including screening (36)

- **Improve access to wide-ranging prevention** and HIV and STI screening;
- **Facilitate access to healthcare services;**
- **Develop a multidisciplinary approach involving associations and institutions** in order to meet trans peoples' needs as best as possible.

62. Improve the care that trans people receive

- **Reinforce the training of healthcare professionals on transition processes** and specific characteristics of the trans population.
- **Build the expertise** of healthcare and medico-social professionals **in terms of sexual health issues and the specific characteristics of this population.**
- Set up appropriate consultation services (gynaecologists, proctologists, addictologists and psychiatrists) at healthcare facilities.

AIM 1.3 - Aimed at Populations from Highly Endemic Regions / migrants

According to the HCSP(7), migrants form a very heterogeneous population with a set of social, legal and epidemiological vulnerabilities. It should be noted that this term covers several different groups:

- foreign-born persons born in a foreign country and living in France (approximately 5.7 million of whom 40% are French by acquisition of nationality according to the 2012 INSEE census).
- people forced to immigrate: people in exile, asylum seekers, refugees who have either a status issued by the 1951 Geneva Convention or subsidiary protection granted by the French Office for the Protection of Refugees and Stateless Persons or the Refugee Appeals Board;
- undocumented persons, living in France but whose stay is not administratively validated, including some foreigners suffering from serious illnesses whose right to a residence permit is determined by their health status.

Female migrants, of whom there are more in France than male migrants, face more problems linked to sexual health - pregnancy and childbirth related issues and sexual violence. These issues are attributable to conditions in the country of origin (sexual mutilation, forced marriage), and the migratory journey (rape, human trafficking). They may be reinforced upon arrival in the host country, as the settling in period is often a precarious time, socially and in terms of health, which increases the risk of exposure to HIV and STIs.

We only have a small amount of information on the reproductive health of migrant women (37), their use of contraceptives and their abortion practices. We know that, overall, first-time mothers are younger and the use of condoms is less systematic.

Despite the decline observed over the last decade, migrants still represent 35% of new cases of HIV in the European Union and European Economic Area. 10% are immigrants from Eastern Europe and Central Europe, and the largest group is that of immigrants from Sub-Saharan Africa. However, it is estimated that between 35 and 49% of Sub-Saharan migrants monitored for HIV in Île-de-France have contracted the virus after arriving in the country (38, 39).

63. Step up sexual health prevention measures aimed at this population, by means of targeted actions or by incorporating this group into an overall prevention and healthcare approach.

- **Carry out screening of migrants and foreigners for hepatitis B and C viruses, HIV infection and other STIs**, but also for pulmonary tuberculosis, diabetes, arterial hypertension and renal failure in a unity of time and place (40);
- **Offer a catch-up vaccination programme, against hepatitis B and HPV in particular;**
- Promote the access of exposed persons from Sub-Saharan Africa to PrEP, particularly women in precarious situations resorting to sexual-economic exchanges to survive;
- **Create primary care centres for high-risk populations** (MCW services, Family Planning or Education Centres (CPEF), hospital Health Service Access Points, healthcare centres, obstetrics & gynaecology services, etc.) ;
- **Set up and develop personal support interviews** for people with a history of STIs and high-risk sexual behaviours;
- **Support the implementation of a "health appointment" systematically offered to newly arrived foreigners** within 4 months of their arrival in France;
- **Promote the use of health mediation and/or linguistic interpretation** services by stakeholders

in the field working with these populations;

- **Ensure the visibility of migrants in "general public" communication programmes** and develop specific programmes to be rolled out according to populations by means of local communication;
- **Promote the access of these populations to rights and healthcare:** ensure the right of all to rapid administrative residence; promote rapid access to a residence and work permit on account of health status for undocumented foreign persons living in France; allow for the inclusion of all foreign persons in therapeutic trials and research protocols without discrimination;
- **Promote access for all**, including unaccompanied foreign minors, to universal health insurance.

AIM 1.4 - Aimed at other populations exposed to HIV and STIs, hepatitis viruses, violence and unplanned pregnancy - people involved in prostitution, criminal offenders and drug users

64. Develop actions targeting the most exposed and vulnerable to STIs and HIV

Prevention and risk reduction actions for these populations must refrain from any value judgement.

- **For people involved in prostitution:**

The number of people involved in prostitution in France is between 20,000 and 40,000 according to the Central Anti-Human-Trafficking Office (OCRTEH) and 400,000 according to the Union of Sex Workers (STRASS) (41).

Prostitution is characterised by its heterogeneity. The 2012 IGAS report (41) and the 2016 HAS report (42) define different places of work, different forms of practice and various operating methods: street prostitution, hostess bars, massage parlours (611 establishments according to the OCRTEH), prostitution at home and at hotels following initial contact online, sexual-economic exchanges (excluding in the Overseas Territories). Prostitution may be the only source of income or it may be practised alongside another activity. All of these differences between individual profiles, such as the various operating methods, are reflected in very different living conditions and income disparity. Nevertheless, the fact remains that prostitution exposes the people involved to some of the same risks.

- **In terms of health:** according to the HAS report, the prevalence of women involved in prostitution infected with *Chlamydia trachomatis* is between 4.8 and 10%; these women are twice as likely to have a chlamydia infection than women in the general population. The same applies for the human papillomavirus, where the prevalence is 15.8%, i.e. twice that of the general population.
- **In terms of violence,** several studies also present data on the frequency of physical and psychological attacks. The 2010 Pro Santé report (43) reveals that between 36 and 50% of women questioned who carry out their activity in the street had suffered violence.

By and large, isolation, clandestinity and financial insecurity seem to be factors that increase risk, which at the same time restrict opportunities to access healthcare services, prevention methods, health insurance and even access to housing. Moreover, people involved in prostitution, for fear of being discriminated against by healthcare professionals and government and police representatives, often conceal their activity, or even do not avail themselves of the many different healthcare facilities and/or public facilities.

- **Promote prevention and risk reduction (RR) promotion actions** for people involved in prostitution aimed to prevent health, psychological and social harm at places of work including on the internet. RR concerns any person involved in prostitution, whether they are a woman, a man, a transgender or intersex person, according to the national framework of risk reduction actions aimed at people involved in prostitution.
- **Promote prevention and information actions for clients;**
- **Simplify the right to be forgotten procedures for people involved in prostitution** who wish to stop their prostitution activity.

- **For criminal offenders:**

This will entail setting up health prevention, education and promotion actions in all penal institutions by including friends and involving families, and by developing partnerships with prevention and RR prevention associations (44).

- **Promote health prevention and education programmes;**
- **Make prevention and RR tools and condoms accessible;**
- **Offer HIV, hepatitis and STI screening upon entering, during, and upon leaving detention, in**

addition to the HBV vaccination;

- Take into account the family and friends of detained persons by involving family support associations in setting up sexual health prevention, promotion and education actions.
- Develop family life units;
- Provide support to incarcerated pregnant women and their children.
- Reinforce health education programmes;
- Build expertise of prison staff in terms of sexual health issues.

- **For drug users:**

This will entail taking into account sexual health issues in activities already existing in systems and developing specific actions taking into account the development of psychoactive substances consumed and their consumption patterns.

For women, substance consumption can increase or decrease desire, and sexual pleasure (a woman's periods may stop, her cervix may dry up, etc.). In the Coquelicot study (45), women are described as engaging more often in sexual relations than men, more often with a casual partner who is a drug user himself (81% vs 58%) and as being ten times more likely to have sexual relations in exchange for drugs or money. Over 30% of women (vs 1% of men) admitted to being involved in prostitution (46). They are also described as more fragile and more dependent on their sexual partner, particularly in order to obtain substances, and more exposed to the risk of domestic violence (47), itself a source of transmission of sexually transmitted infections. Consequently, they are less able to negotiate condom use and consider that the emotional risk, i.e. losing their partner, is greater than the risk of contracting an infection (48).

The use of psychoactive substances, whether injected (Slam/Chemsex) or otherwise, especially those based on synthetic products, and particularly by MSM since 2010 and currently by certain young people, has specific characteristics in respect of exposure to STIs, particularly HIV and HCV and other health risks, and in particular mental health risks.

- **Incorporate sexual RR in the projects** of social and medico-social addiction services and facilities;
- **Take into account emerging practices combining sexual practices and the consumption of psychoactive substances** in "approachable" strategies in medico-social facilities;
- **Put in place prevention and education actions combining sexual health and the consumption of psychoactive substances** specifically aimed at women (49) and young people;
- **Develop partnership networks with stakeholders from sexual health associations and institutions to meet the needs of drug users as best as possible;**
- **Systematise screening services for STIs, HIV and hepatitis B and C, particularly by making RDTs available;**
- **Improve HBV vaccination for drug users;***
- **Promote the entitlement and continuation of rights taking into account the specific characteristics of drug users;**
- **Build the expertise of CAARUD, CSAPA and Clinics for Young Drug Users (CJC) staff in terms of sexual health issues.**

AIM 2 - TAKE INTO ACCOUNT THE SEXUALITY OF PEOPLE WITH DISABILITIES AND ELDERLY PEOPLE

The survey on sexuality in France (17) reveals that sexual ageing has changed dramatically and that it has been marked by all the changes that have affected people's life trajectories over the past few decades - medical support for the menopause, increased female autonomy, and greater marital mobility.

As such, according to surveys conducted in 1970 (50) and 2006 (17) respectively:

- 90% of women aged over 50 who live with a partner are sexually active, compared to 50% in 1970;
- 55% of women aged over 50 think that sexual intercourse is necessary to well-being, compared to 33% in 1970;
- Indeed, sexual activity later in life is solely motivated by desire and libido. It is no longer a question of procreation;
- Nonetheless, more women than men aged 60-69 do not have a sexual partner (37% of women compared to 16% of men).

Moreover, psychological and physiological ageing, certain diseases, and the profound social changes that affect senior citizens can constitute barriers to a fulfilling sex life.

As such, erectile dysfunction and desire disorders are more common among over 50s. Many studies show that erectile dysfunction, which affects more than one in two men, should - until proven otherwise - be considered an early marker of cardiovascular morbidity and mortality (51).

Lastly, institutional living is an additional factor linked to a lack of privacy. Sexual activity in institutions is often considered as nonexistent, or even disturbing.

By and large, disabled people are at the same level of risk, or even at higher risk, of HIV infection than the general population, yet they are rarely the focus of adapted prevention and screening operations. Moreover, they are often victims of sexual abuse, due to a number of vulnerabilities. In addition to this increased risk, there are limitations related to their living conditions and the lack of privacy they often endure (7).

65. Promote a positive view of the sexuality of people with disabilities and elderly people.

This entails changing society's perspective on the existence of sexuality in elderly people and people with disabilities, and facilitating meetings and social life while protecting the privacy and respect of every individual.

- **Draw up good practice standards** relating to privacy, respect for the freedom and dignity of persons, **for staff at institutions housing elderly people and disabled people**;
- **Set up sexual health and health promotion programmes in social and medico-social services and facilities (ESMS) for disabled people by means of appropriate education and support to families and institution staff**;
- **Adapt education to each individual's specific characteristics, while respecting their privacy and their need for confidentiality. Promote training of healthcare and education professionals on both the issue of sexuality and ethical concerns in these professions (52)**;
- **Facilitate contact between physically disabled people, facilitate access to mechanical means to achieve sexual satisfaction while promoting resources facilitating disabled people's autonomy (52)**;
- **Highlight and share measures undertaken by facilities and associations in the field of disability**;
- **Incorporate support for the interpersonal life of mentally disabled people into each individualised project, in close collaboration with their families**;
- **Draw up guidelines for healthcare professionals** in order to support women and couples at the onset of age-related sexual dysfunctions.

66. Allow for sexual expression within facilities housing senior citizens, elderly people (taking into account the increase in chronic diseases and long-term conditions) and people with disabilities.

- **Support medico-social facilities and services (ESMS)**, in taking into account the right to privacy and an interpersonal and sex life of people with disabilities and elderly people with reduced autonomy.
- **During compliance and inspection visits in these facilities, check that residents' sex lives are respected and not excluded by internal regulations.**
- **Develop awareness raising and training actions on sexuality aimed at professionals in facilities housing elderly people and people with disabilities.**

AIM 3 - TAKE INTO ACCOUNT THE SEXUALITY OF PEOPLE WITH CHRONIC DISEASES

67. Take into account the impact of chronic diseases on the sex lives of people of all ages

- **Train professionals** on the implications of chronic diseases management on sexuality.
- **Apply supportive care mechanisms related to sexual problems.**

PRIORITY V - PROMOTE SEXUAL HEALTH RESEARCH, KNOWLEDGE AND INNOVATION

Research in the field of sexual health covers many fields. It can focus more specifically on the health status and needs of specific groups, problems observed and the supervision thereof in the Overseas Territories, or on the role of medico-administrative databases in providing an insight into citizens' sexual health.

Vision	<ul style="list-style-type: none">• Develop research and promote the use of research findings and data in the National Sexual Health Strategy implementation process.
Findings	<ul style="list-style-type: none">• Develop the use of databases (big data), scientific information and health research findings priorities (ORDER MAY BE SKEWED)• Increase knowledge in epidemiology (therapeutic) pharmacology, sociology and anthropology in the field of sexual health• Develop multidisciplinary and intervention research and promote screening in terms of prevention and convincing innovations

AIM 1 - STRENGTHEN HIV MONITORING BY SETTING UP SEXUAL HEALTH INDICATORS

68. Conduct another survey on sexuality in France, in order to compare the development of sexual health indicators in relation to the survey on sexuality in France (INSERM, 2005) and with surveys on sexuality in the Europe Region.
69. Conduct regular surveys on the sexuality of specific populations on the basis of knowledge.
70. Conduct a regular survey on contraceptive practices in France and on the development of unplanned / unwanted pregnancies.
71. Measure and monitor antibiotic resistance¹⁰, particularly for gonorrhoea.
72. Improve the monitoring of emerging sexually and genitally transmitted infections.
73. Use survey data to improve knowledge on victims of sexual violence and aggressors.
74. Put in place - at academic level - an information system to collect and analyse data on sexuality education actions.
75. Establish indicators on high-risk behaviours (sexual behaviours and alcohol and psychoactive substance addiction).
76. Improve knowledge on the sexuality of adolescents under 15

¹⁰ Interministerial road map for control of antibiotic resistance,
http://social-sante.gouv.fr/IMG/pdf/feuille_de_route_antibioreistance_nov_2016.pdf

AIM 2 - PROMOTE SEXUAL HEALTH INTERVENTION RESEARCH AND INNOVATION

77. Promote intervention and community research and the role of mainstream education in the appropriation of information.
78. Identify and pool promising local experience, to then evaluate, share and deploy this experience throughout France.
79. Support existing and future initiatives for disabled people, particularly trial projects that involve helping disabled couples to set up home in a mainstream environment.
80. Work towards improving treatment and prevention mechanisms and obstacles to accessing them faced by the target populations.

AIM 3 - DEVELOP KNOWLEDGE OF PSYCHO-SOCIAL SCIENCES

Research in the field of sexual health covers many fields. It can focus more specifically on:

81. knowledge of citizens' sexual health and documenting emerging and societal phenomena.
 - The role of the internet and social networks;
 - The sexual health needs of specific groups;
 - Needs in terms of access to healthcare and social and legal protections for asylum seekers and refugees in the field of sexual and reproductive health;
 - New representations of sexuality among young people, including adolescents under 15, and the development of sexual practices in order to adapt sexual education content to modern day realities and uses;
 - Health knowledge on sexual health issues concerning people involved in prostitution;
 - The health of transgender people (side effects of hormonal treatments, etc.);
 - The practice and use of psychoactive substances, including new synthetic products, in a sexual context, and appropriate means of sexual health intervention;
 - Specific issues observed in the Overseas Territories and the monitoring thereof.

82. Identify and analyse mechanisms that generate social and gender inequalities in the field of sexual health.
83. Ensure that everybody can participate in research¹¹, whether or not they are covered by a health insurance scheme.

AIM 4 - PURSUE CLINICAL RESEARCH IN THE FIELD OF SEXUAL HEALTH

84. Promote research in the field of male contraception.
85. Promote research into alternatives in the field of female contraception.
86. Promote research into STI prevention and screening.

AIM 5 - MAINTAIN A HIGH LEVEL OF RESEARCH INTO HIV/AIDS AND STIs

87. Update recommendations for the management of sexually transmitted infections in terms of health, social, ethical and organisational issues in the form of a single report covering HIV, hepatitis viruses and STIs, according to scientific and therapeutic developments, the epidemiological context and advances in the field of prevention and screening.
88. Support and evaluate strategies to eradicate the HIV and STI epidemic in France.
 - **Strengthen research into risk factors for HIV and STI acquisition among Populations from Highly Endemic Regions** and into access to screening, prevention and treatment.
 - **Develop intervention and innovative research into screening and prevention for all key populations.**
 - **Initiate intervention research into access to prevention and treatment in the Overseas Territories.**
 - **Develop research into epidemiological indicators relevant to monitoring the HIV and STI epidemic.**

¹⁰ Ruling n°2016-800 of 16 June 2016 - Art. 1

PRIORITY VI - TAKE INTO ACCOUNT THE SPECIFIC CHARACTERISTICS OF THE OVERSEAS TERRITORIES TO IMPLEMENT THE SEXUAL HEALTH STRATEGY AS A WHOLE

Vision	<ul style="list-style-type: none">• Guarantee all Overseas populations optimal conditions for healthcare development, by means of prevention, access to care and treatment
Priorities	<ul style="list-style-type: none">• Strengthen sexuality education• Improve access to screening tools and contraceptives• Promote access to healthcare

All of the priorities of the National Sexual Health Strategy must be rolled out in the Overseas Territories. They supplement, develop and elaborate upon Action 5.1 of the health strategy for the Overseas Territories (53). This entails guaranteeing all overseas populations optimal conditions for healthcare development, by means of prevention, access to care and treatment, by focussing on innovations and possibilities of the Overseas Territories and taking into account the diversity of the Territories. The group of targets and indicators provided for in priorities 1 to 4 will be implemented for these Territories.

The aims of this approach are to:

- Improve citizens' health status, strengthen wide-ranging prevention, and decrease social and regional inequalities in terms of healthcare;
- Improve the monitoring, assessment and management of health risks;
- Meet people's needs in the field of autonomy (ageing and disability);
- Strive for excellence and efficiency of the health system in the Overseas Territories and respond to the major challenges of the 21st century (medical demographics, teaching, research and innovation);
- Reduce (geographical and financial) inequalities in terms of access to care and improve medical care;
- Step up efforts to combat violence (prevention of sexist and homophobic behaviour, provision of care for victims);

89. Strengthen health promotion in collaboration with the national education system and the school health service,
by utilising Family Planning or Education Centres (CPEF) and Free Information, screening and Diagnosis Centres (CeGIDD), by expanding access to condoms in schools.

90. Make condoms more readily available in the Overseas Territories

91. Improve access to contraception

by examining the possibility of expanding free access to contraceptives to minors under 15.

92. Increase access to STI and HIV/AIDS screening and the vaccination of all Overseas populations:

expand the screening options available with rapid diagnostic tests (RDTs) and self-tests, widespread screening for cervical cancer, increased coverage of vaccination against hepatitis B and HPV.

In the Overseas Territories, the priority should be reducing the time between when someone becomes infected with HIV and them discovering their HIV status. screening should be further targeted, and health pathway support - particularly community support - should be promoted. Furthermore, non-discriminatory health facilities should be created where people can talk freely about their practices and prevention tools appropriate for these practices.

93. Promote access to care, particularly by means of greater support to the implementation of health mediation.

94. Strengthen cooperation for each geographical region: French *départements* in the Americas; Indian Ocean region; strategy to be drawn up with the Comoros for Mayotte.

95. Combat violence against women and discrimination against HIV-positive people.

MANAGEMENT OF THE NATIONAL SEXUAL HEALTH STRATEGY

The National Sexual Health Strategy defines the national policy framework, shared at interministerial level, for improved sexual health. Its governance involves all of the relevant ministries at national and regional level, in order to define common aims, ensure the complementarity of approaches and to implement, monitor and evaluate programmes jointly. These aims require the implementation of certain actions and tools.

Management of the National Health Strategy

At national level, the strategy will be managed by a **National Sexual Health Strategy Steering Committee**, under the aegis of the Directorate-General for Health, bringing together representatives from other Directorate-Generals of the central administration in the field of health and other central administrations of the Ministries involved (Ministry for Women's Rights, Ministry of National Education, Ministry of Agriculture, Ministry of Labour, Ministry of Youth and Sports, Ministry of Foreign Affairs and International Development, Ministry of Justice, Ministry of Local Authorities, and Ministry of Overseas Territories).

It will also comprise representatives from national institutions and agencies (National Public Health Agency, National Agency for AIDS and Viral Hepatitis Research, etc.), the National AIDS & Hepatitis Viruses Council, the National Health Insurance Fund for Employees (CNAMTS), professional associations, scientific societies, user associations and field structures, particularly the CeGIDD, CPEF, and existing coordination structures in the field of STIs and HIV, in particular COREVIH.

The governance established must allow for this strategy to be deployed as part of a **dynamic approach and adapt aims and priorities** to the advancement of scientific knowledge, changes in society and forms of communication.

With this in mind, the Steering Committee will also consult experts (expert group on the medical care of people infected with the hepatitis B or hepatitis C viruses, and experts on the strategy's different priorities), individuals qualified to support the development of the National Strategy by means of recommendations, and user representatives.

The National Steering Committee will be assigned with:

- carrying out the organisation, coordination and monitoring of the strategy's implementation;
- informing and promoting the action of the many stakeholders from institutions and associations and private stakeholders contributing to meeting the aims set (observation and dissemination of innovative projects and good practices);
- carrying out a quantitative and qualitative assessment of its deployment in France.

The National Steering Committee will roll out all of the guidelines of the **strategy, not only the operational actions listed in the strategy**.

During its installation in 2017, the Committee will approve the three-year steering and monitoring roadmap for the National Sexual Health Strategy.

For their implementation, the guidelines of this strategy will be **deployed and adapted within the operational strategies of the various stakeholders**: central administrations of the Ministries involved and their decentralised services, and the public establishments and agencies involves, regional health agencies, local authorities, health insurance network, professionals, associations and other stakeholders involved, particularly Regional Coordination Committees for the Fight against HIV (COREVIH).

The interministerial roadmap will identify the management of different measures, at national and regional level, the main milestones of their operational implementation and the levers to be mobilised or developed in order to successfully carry out their deployment.

Mobilisation of all stakeholders at national level

At national level, the different levers of public action in the field of health will be mobilised:

development of the legislative, regulatory and financial framework, implementation of prevention campaigns and tools, production and dissemination of good professional practice recommendations, incorporation of incentive measures into the remuneration of healthcare professionals, etc.

With this aim in mind, the strategy's priorities will have to be transposed to partners' strategic documents: multi-year work programmes of national institutions and agencies ((ANSP, ANSM, HAS, etc.), objective and management agreement with health insurance (COG), national agreements with healthcare professionals, and interministerial framework agreements.

From now on, the public health framework partnership agreement between the Ministry of National Education, Higher Education and Research and the Ministry of Social Affairs and Health will help to strengthen intersectorality at national, regional and academic level, to promote a favourable environment for health and educational success. Future public health framework partnership agreements with other Ministries (particularly the PJJ) will pursue this dynamic.

Mobilisation of all stakeholders at regional level

The ARSs define and implement regional health policy as part of their Regional Health Project (PRS), authorised for a five-year period. Actions established to specify the priorities of the Sexual Health Strategy at regional level, in accordance with the specific characteristics of the regions, are also designed to be included **in the regional health plan**, on the basis of the regional diagnosis carried out by the ARS.

It will be the regional framework for the mobilisation and coordination of stakeholders in the regions.

Sexual health services are provided by a number of structures and systems operating in the field of sexual health in France (Appendix 3). Alongside these structures, there are a number of intermediaries that contribute to sexual health promotion and prevention, particularly National Unions of Healthcare Professionals (URPS), Regional Coordination Committees for the Fight against HIV (COREVIH), associations such as associations for the fight against AIDS and hepatitis and the French Movement for Family Planning, specialist hepatitis centres, and scientific societies.

To ensure operational application of the aims and formalise the commitments of each of these stakeholders as part of the regional health plans, ARS will utilise all of the partnership tools available to them, in particular:

- Multi-year Contracts of Objectives and Means (CPOM) and local health contracts with local stakeholders;
- agreements with partner associations;
- incorporation of sexual health promotion and prevention topics in existing partnership agreements between ARS, local authorities and national education and higher education services, in order to link the PRS to the other existing regional strategies, in agreements between ARS and regional education authorities which formalise common strategic guidelines;
- systematic incorporation of sexuality education into agreements between ARS and universities in order to formalise strategic guidelines for students;
- signing of contracts with regional professional healthcare communities created by the law regarding the modernisation of the French healthcare system and which - at regional level - bring together healthcare providers and social and medico-social stakeholders, for better structuring of health pathways in the regions;
- incorporation of the improvement of the sexual health pathway in the work priorities of the ARS/Health Insurance Coordination Commission;
- the role of COREVIH, in the context of their duties in terms of organisation, coordination and expertise on sexually transmitted infections including HIV, in a sexual health approach. The ARS is responsible for strategic planning, which may be carried out in collaboration with the COREVIH, on the basis of a shared regional diagnosis. The ARS is in charge of coordinating, monitoring and analysing the activity of authorised centres. The ARS can delegate the operational implementation of coordination, monitoring and analysis duties to a CeGIDD or to a COREVIH.

Implementation to be evaluated for regular updating of the national roadmap

To evaluate the implementation of the systems put in place as part of the strategy and their impact in terms of public health, the National Steering Committee will utilise the indicators defined in the summary table of targets and will implement the following actions:

- Organise reporting of quantitative and qualitative indicators making use of monitoring tools (data collection overview) and aim implementation tools;
- Prepare a strategy monitoring report
- Organise the monitoring and evaluation of PRS in terms of "sexual health";
- Produce and analyse reports on the activity of prevention and screening structures;
- Define regional activity indicators in a standardised form.

On the basis of this evaluation, the Steering Committee will propose an update of the roadmap every three years, based on the indicator monitoring table, results of the actions carried out, scientific developments and epidemiological data.

International governance: improve the international normative framework with regard to health and sexual rights

Beyond the National Sexual Health Strategy, France harnesses its values and assets to tackle major health challenges in the world and is continuing its efforts to improve the international normative framework regarding sexual and reproductive health.

- Improve the normative framework with regard to health and sexual rights within the European Union; in multilateral forums (United Nations - UN): World Health Organization (WHO), United Nations Population Fund (UNPF), United Nations Economic and Social Council (ECOSOC), Security Council; within dedicated programmes and funds: Global Fund to Fight AIDS, Tuberculosis and Malaria/GAVI Alliance/World Bank, etc. ;
- Promote French expertise on health and sexual and reproductive rights abroad (particularly via the international technical expertise agency(Expertise France) and the French Development Agency(AFD).
- Develop bilateral cooperation with regard to health and sexual and reproductive rights, particularly with priority countries as defined by the Interministerial Committee on International Cooperation and Development(CICID), in particularly Western and Central African countries;
Coordinate French positions in terms of health and sexual and reproductive health, particularly on population and sexual and reproductive rights issues.

Summary table of targets

I - INVEST IN THE PROMOTION OF SEXUAL HEALTH, IN PARTICULAR AMONG YOUNG PEOPLE, AS PART OF AN OVERALL AND POSITIVE APPROACH
100% of young people have received high-quality education in sexuality and the associated risks (STIs, unwanted pregnancies) throughout their school curriculum
100% of basic or continued training bodies for healthcare professionals offer complete overall sexual health training
II - IMPROVE THE HEALTHCARE PATHWAY IN TERMS OF STIs INCLUDING HIV AND HEPATITIS VIRUSES: PREVENTION, SCREENING, AND TREATMENT
In 2020, 95% of people living with HIV are aware of their HIV status
In 2020, 95% of people tested who are infected with HIV receive the recommended anti-retroviral treatment
In 2020, 95% of people receiving the recommended anti-retroviral treatment have a lasting undetectable viral load
In 2023, 75% of adolescents covered by the hepatitis B vaccination (95% in 2030)
In 2023, 60% of adolescents covered by the HPV vaccination (80% in 2030)
Reduce the incidence of the most common and most serious STIs - syphilis, gonorrhoea, chlamydia, lymphogranuloma venereum (LGV) (reference year: 2023)
III-IMPROVE REPRODUCTIVE HEALTH
Reduce the number of unwanted/unplanned pregnancies among women by one third
90% of requests for abortion are handled within the periods defined by the National Health Authority(5 days)
Keep congenital syphilis at a low rate
Facilitate access to permanent contraception (vasectomy, tubal ligation at 5%)
IV-MEET THE SPECIFIC NEEDS OF THE MOST VULNERABLE POPULATIONS
Reduce the incidence of bacterial STIs among key populations
'95-95-95' objective for HIV in the key population
80% vaccination coverage in the key populations

APPENDIX 1: DEFINITIONS

(54,55)

Reproductive health:

Reproductive health was defined at the 1994 International Conference on Population and Development as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. "

Sexual health:

The WHO definition of sexual health was established at an International Expert Meeting in 2002 which gave an overview of sexual health: "Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual health is a central aspect of being human throughout life that encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed."

The 2002 WHO (WHO, 2006) definition of sexuality recognises the significant role played by intrinsic factors (biological, psychological and spiritual) and extrinsic factors (interpersonal, economic, legal, etc.) in sexual health.

Beyond this definition, it has been demonstrated that poor sexual health outcomes are determined by a complex interaction of factors at different, but connected, levels:

The macro level, where laws, their bans and recommendations, have an effect on society;

- The intermediate level, where the local environment, social networks, cultural, economic and political aspects influence variables such as access to services and information;
- The micro level where the innate characteristics of an individual (sex, physical and mental health, ethnicity, age, etc.), and acquired characteristics (due to education, social networks and experience of social life, cultural, economic and political factors) have a direct influence on sexual health.

The basic principles of sexual health are promoting positive aspects of sexuality - autonomy, well-being and fulfilment, and promoting and protecting human rights. Healthy sexuality is defined as when an individual has a satisfactory and safe sex life, a positive attitude towards sexual relations and the freedom of sexual identity and gender expression.

Autonomy: autonomy recognises an individual's right to self-determination in all aspects of their sexual health and their well-being. In general, autonomy means that an individual has the ability to make informed, uncoerced decisions in all aspects of their life. In terms of sexual health, autonomy is the foundation of healthy societies and individuals. However, autonomy cannot usually be reached by individuals alone. International institutions, governments and families all play a role in promoting and protecting autonomy in terms of sexual health.

Well-being: well-being is a concept widely used in public discourse but there is no consensus on its meaning or on its determining factors. In the context of sexual health, well-being encompasses quality of life issues for individuals, communities and societies. Moreover, it provides for the creation of favourable environments that promote and protect the achievement of personal sexual health objectives, while acting responsibly towards others.

Sexual fulfilment: the possibility for each man, woman and couple to alter their sex life according to their desires.

Sexuality:

Sexual health is "a central aspect of being human throughout life that encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, ethical, historical, religious and spiritual factors." (WHO, 2012).

Achieving sexual health is linked to the degree to which human rights are respected and effectively protected. Sexual rights encompass certain rights that are already recognised in international and regional documents on rights in general, in consensus documents and in national laws. The application of existing rights to sexuality and sexual health constitutes sexual rights. Sexual rights protect everyone's rights to fulfil and express their sexuality and to enjoy good sexual health, taking due account of the rights of others and in a context of protection from discrimination.

Sex: describes the female or male characteristics defining human beings that are determined biologically.

Sexual orientation:

Sexual orientation refers to the sustainable model of self-assessment and self-identification, self-classification, attraction and behaviour (emotional, romantic and/or sexual) towards men, women, or both sexes. As such, while sexual orientation is inherent in an individual, it is expressed in terms of feelings, thoughts and relations with others. Identity linked to sexual orientation can encompass both personal identity (self-perception in accordance with sustainable models of attraction and behaviour) and social identity (collective, belonging to social group based on shared sexual orientation).

Gender identity:

The WHO definition of gender identity refers to the "socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women." We are born male or female, but we learn to become a young man or a young woman, and then a man or a woman. This determined behaviour, reinforced at social level, that is often legal in nature, defined the roles attributed to each sex and the relations between them. When identity and gender do not correspond to the assigned sex, individuals may identify themselves as transgender or trans. Moreover, the idea that an individual has of relations between the sexes and of equality can change according to the context and circumstances.

Definition of human rights in terms of sexual health:

In 1994 in Cairo, at the International Conference on Population and Development (ICPD) 179 countries undertook to set up an action programme recognising that the right to sexual and reproductive health, the empowerment of women, and gender equality are essential in order to reduce poverty and promote development.

"Human rights are inherent to human beings; however, recognition of inherent rights does not create rights per se. Human rights are above cultural values. If a particular culture has a practice that contravenes a human right, the cultural value should be changed, as in the case of the cultural practice of female genital mutilation (...) The human rights approach to health promotion has been explicitly stated in the case of the promotion of reproductive health. Since protection of health is a basic human right, it follows that sexual health involves sexual rights." (PAHO, WHO, WAS, 2000).

The International Conference on Population and Development beyond 2014 gives a central role to sexual and reproductive health, and health and development rights.

APPENDIX 2: KEY FIGURES

25% of schools report not having put in place any sexuality education despite the legal obligation, showing that sexuality education is still insufficiently developed, according to the survey carried out by the High Council for Equality (8)

Prevalence of Sexual Violence in France:

62,000 women aged 20 to 69 say they have been **victims of rape or attempted rape** (56).

553,000 women aged 20 to 69 and 185,000 men say that they have been **victims of at least one sexual assault other than rape** (56) (56)

One in seven women (14.5%) and **one in twenty five men** (3.9%) said that they had experienced **at least one form of sexual assault** (including rape and attempted rape other than harassment and exhibitionism) at some point in their life. Out of these people, **3.7% of women** and **0.6% of men** had been **victims of at least one rape or one attempted rape** at some point in their life. (15)

Sexual violence suffered at some point in life was reported 2 to 3 times more often among deaf and hard of hearing populations in France than among the **general population** (57).

Female Genital Mutilation

There are 53,000 circumcised women living in France(37)

Significant discrimination related to gender and sexual orientation still exists:

31% of men who have sexual relations with other men have been victim to homophobic acts over the past 12 months(16)

44% of women who have sexual relations with women feel discriminated against by the professional attitude of gynaecologists (58)

80% of PLWHA who suffered discrimination attributed this to their HIV-positive status; 47% of respondents who suffered discrimination attributed this to their sexual orientation; 10.2% of respondents had been refused medical care.

Contraceptives:

The most widely used methods of contraception by women aged 15 to 49 in France are the pill (42.7%), the coil (25.4%) and condoms (12.5%). The coil is very rarely used by women under 24 without children (5.8%) (59)

Male Contraception:

<1% of men in France have had vasectomies (between 15 and 20% in the UK and the Netherlands) (29)

Emergency Contraception:

24.4% of women aged 15 to 49 reported to have used emergency contraceptive at least once in their life (17)

Pharmacists are often the first (or even the only) person consulted in the context of a request or advice regarding emergency contraception (60).

Unwanted pregnancy:

7.7% of sexually active women aged 15 to 19 reported having had an unwanted pregnancy in the past 5 years.

1/3 of pregnancies unplanned in France, one of the countries offering the most extensive and highly medicalised contraceptive coverage.

Abortion:

Every year, abortion affects approximately 1.5% of women of reproductive age (1.4% for mainland France). The number of abortions carried out has been stable over time, with approximately 200,000 abortions carried out each year (62)

The abortion rate is highest among 20-24 year olds (27 in 1000), followed by 25-29 year olds (25.5 in 1000). In women under 20, the abortion rate has been declining since 2010 (7.6 in 1,000 among 15-17 year olds and 19.5 in 1,000 among 18-19 year olds) (30).

2 in 3 women who have an abortion use a method of contraception (30).

Abortions are more carried out more frequently in the Overseas Territories than in the mainland France among 15-17 year olds (7.6 for 1,000 in 2015, with this figure increasing to 20 for 1,000 in the Overseas Territories) (63).

HIV

6,600 people were diagnosed HIV-positive 2014 (70% in a hospital and 30% in the community), including 3,100 migrants (48 %) 2/3 of whom were born in Sub-Saharan Africa (64) Significant

increase in the number of HIV-positive diagnoses among MSM between 2011 and 2014 (stable in all other population groups) (65) Persistent amount of loss of opportunity linked to a delay in screening among foreign-born men, particularly those from Sub-Saharan Africa (Public Health France data, BEH 41-42 of 29 November 2016). From the HIV-positive diagnoses in 2013, median age at diagnosis was 36.6 years. People aged 35 to 49 represented 70% of diagnoses in 2013, this proportion having decreased over time (77% in 2003, $p < 10^{-3}$). The proportion of people aged 50 and over was 17% in 2013, having increased between 2003 and 2012 (from 13% to 18%, $p < 10^{-3}$). The youngest people, under 20 years old, represented 13% of HIV-positive diagnoses in 2013, this proportion not having changed significantly since 2003 (65). New infections: Highest rates in French Guiana (18 for 10,000), Guadeloupe (7 in 10,000), Île-de-France (4 for 10,000) and Martinique (3 for 10,000). People unaware of their HIV-positive status: Very high rates in the French *départements* in the Americas: French Guiana (66 for 10,000 inhabitants), Guadeloupe (27 for 10,000), Martinique (13 for 10,000) compared to 9 for 10,000 in Île-de-France. In mainland France, 50% of new HIV infections and people unaware of their HIV-positive status in three regions of mainland France (Île-de-France, PACA (Provence-Alpes-Côte d'Azur) and Rhône-Alpes). These three regions also represent 50% of undiagnosed people.

Increase in the proportion of PLWHA patients diagnosed with age- and treatment-related comorbidities (26).

Other STIs

Young people aged 15 to 24 accounted for approximately 41% of STIs (HIV, syphilis, gonorrhoea and chlamydia) in 2014, +10% compared to 2012 (10).

Chlamydia infections:

In 2015, the majority of patients diagnosed with chlamydia were women (64%). The age groups most affected were those aged 15-24 among women (65%) and 20-29 year olds among men (61).

Rectal lymphogranuloma venereum: the number of cases of rectal LGV increased by 47% and of cases of non-L chlamydial rectal infections increased by 92% between 2013 and 2015. The epidemic affects virtually only men who have sex with men (MSM), who represented 98% of cases of LGV and non-L rectal infections in 2015 (24).

Early syphilis:

The number of cases of early syphilis increased by 56% among MSM between 2013 and 2015. Among heterosexuals, despite relatively low numbers, the number of cases recorded also increased over the same period (+85% among women and +75% among men) (24).

Gonorrhoea:

Between 2013 and 2015, the number of cases of gonorrhoea increased by approximately 100% among MSM, by 32% among heterosexual women, and by 8% among heterosexual men (24).

Data on vaccination

Hepatitis B: vaccination coverage among children aged 24 months and over (3 doses) = 81.5% in 2013 and in 15 year old adolescents = 43% en 2009 (67%);

Papillomavirus: vaccination coverage of 16 year old women (3 doses) = 28.3% in 2010 and 17.2% in 2014) (7).

Sexual behaviours in France

The age at first sexual intercourse for girls was 17 years and 8 months, compared to 17 years and 4 months for boys.

The average number of sexual partners appears to be very different for women and men: 4.4 for women, versus 11.6 for men in 2006.

Among people who had had sexual intercourse in the previous 12 months (87.2% of women and 91.4% of men), the average monthly number of intercourses was 8.7 for both sexes, but this trend declined with time spent in a couple, with age, and with whether or not individuals live together. 18% of men and 33% of women did not have sexual intercourse.

4.0% of women and 4.1% of men aged 18 to 69 reported having engaged in sexual practices with a partner of the same sex.

88% of both women and men said that their sex life was 'very good' or 'satisfactory' (17).

Sexual disorders (17)

The most common (often and sometimes) male sexual dysfunctions were erectile dysfunctions 16%, premature ejaculation 39%, desire disorders 22%, and orgasmic disorder 14%.

Among women, the most common (often and sometimes) female sexual dysfunctions were painful sexual intercourse 16%, orgasmic disorders 36%, and desire disorders 35%.

The help-seeking behaviours for these sexual problems were very similar among men and women – among those suffering from sexual disorders, 32.9% of men and 26.4% of women had not taken any steps towards resolving their difficulties.

APPENDIX 3: STRUCTURES AND SYSTEMS IN THE FIELD OF SEXUAL HEALTH

Sexual **health services** are provided by a number of structures and systems operating in the field of sexual health in France:

- Specialised hospital department consultations (maternity, gynaecology, urology, infectious diseases, legal medicine, chronic diseases, etc.);
- Private healthcare professionals;
- Healthcare centres;
- Free Information, screening and Diagnosis Centres (CeGIDD) for infections with the human immunodeficiency virus (HIV) and hepatitis viruses and sexually transmitted infections (STIs);
- Marriage and family counselling information facilities (EICCFs);
- Family Planning or Education Centres (CPEF);
- Maternal and Child Welfare (PMI) services;
- Perinatal Health Networks (RSP);
- Health services in schools and universities;
- Structures focusing mainly on treatments such as family planning consultations;
- Medical units in prisons;
- CSAPA and CAARUD;
- Health Service Access Points (PASS).

APPENDIX 4: THE 17 SUSTAINABLE DEVELOPMENT GOALS (SDGs) OF THE UN 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT

Almost all of the 17 Sustainable Development Goals (SDGs) have a health component or will contribute to improving health. Sustainable Development Goal 3 is specifically dedicated to health and well-being. It seeks to "ensure health and well-being for all, at every stage of life".



The Sexual Health Strategy primarily comprises 27 targets:

- 1.3 put in place social protection measures and systems for all
- 2.2 provide for the nutritional requirements of pregnant and breastfeeding women and children
- 3.2 end the preventable deaths of new-borns due to sexually transmitted infections (STIs) including HIV
- 3.3 put an end to HIV/AIDS and STI epidemics and prevent their consequences
- 3.4 reduce organic and functional sexual disorders, prevent cancers of the sexual organs and promote mental health and well-being
- 3.5 prevent the abuse of licit and illicit drugs and alcohol
- 3.7 guarantee the access of all to sexual and reproductive healthcare services, including for family planning, information and educational purposes
- 3.8 ensure that everyone benefits from universal health coverage, including respect for, and confidentiality of, their sex and reproductive life
- 3.9 reduce infertility and cancers of the sexual organs due to chemical substances
- 4.2 ensure that all girls and all boys have access to sexuality education activities, as part of an overall approach
- 4.5 eliminate (gender, vulnerability and disability) inequalities in terms of sexual education and sexual and reproductive health services
- 4.7 ensure that all pupils acquire the knowledge and skills required to promote sustainable development, particularly through education supporting human rights, gender equality, nonviolence and the appreciation of cultural diversity
- 5.1 put an end to all forms of discrimination against women and girls
- 5.2 eliminate all forms of violence against women and girls from public and private life, including trafficking and sexual exploitation
- 5.3 eliminate all harmful practices, such as female genital mutilation
- 6.3 reduce emissions of chemicals to combat infertility and cancers of the sexual organs
- 8.7 put an end to sexual slavery and human trafficking
- 9.5 reinforce resources for (sociological, anthropological, medical and vaccine) research and evaluation
- 10.2 empower all individuals in allowing them to express their sexuality while respecting diversity
- 10.3 reduce inequalities and discriminatory practices in terms of gender, sex and orientation
- 11.1 ensure the access of all to premises where they can engage in sexual practices in privacy
- 12.4 reduce the discharge of chemicals into the air, water and soil and waste so as to combat infertility and cancers of the genitals

- 15.9 incorporate the protection of ecosystems and biodiversity into strategies for reducing the risk of infertility and cancers of the genitals
- 16.1 reduce all forms of sexuality-related violence (physical, moral, emotional and social) and associated mortality rates
- 16.3 promote the rule of law with respect to all sexualities and conditions of equality
- 17.6 strengthen international cooperation to better understand sexuality-related cultural diversity
- 17.17 encourage and promote civil society governmental partnerships to implement sexual health strategies

APPENDIX 5: THE NATIONAL SEXUAL HEALTH STRATEGY AND ITS INTERFACES WITH THE OTHER NATIONAL PLANS AND STRATEGIES AND PLANS AND FRAMEWORKS

National Health Strategy	National Research Strategy	National Strategy for the Overseas Territories
National E-Health Strategy		

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